USING HUMAN RIGHTS FOR MATERNAL AND NEONATAL HEALTH:

A tool for strengthtening laws, policies and standards of care

A Report of Indonesia Field Test Analysis

World Health Organization

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A tool for strengthening laws, policies and standards of care

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Introduction

Praises shall be to the Almighty for the great blessings and assistance that the report document on "Using Human Rights for Maternal and Neonatal Health: A tool for strengthening laws, policies and standards of care, could be finalized in due time. Titled as *A Report of Indonesia Field Test Analysis,* it has seen a slightly long process and enjoyed fruitful involvement of a number of related stakeholders, both from the government institutions and NGOs.

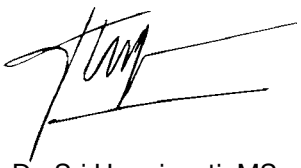
The Tool has been developed by WHO Headquarters in Geneva in collaboration with *the Harvard School of Public Health.* Indonesia has served as one of the first three countries (the others being Brazil and Mozambique) to undertake a field test, which was held from May 2005 to September 2006. The field test process was handled by a National Project Team chaired by the Director General of Community Health, Ministry of Health R.I, involving several representatives from the Ministry of Law and Human Rights, BKKBN, Faculty of Public Health – University of Indonesia, Women's Health Foundation as well as WHO Headquarters Geneva and WHO Indonesia. Funding support has been jointly provided by UNICEF, UNFPA, GTZ and the Ford Foundation.

The very process itself started from the collection of maternal and child health data and information relating to the relevant laws and other regulations. Data collection was done at the central level, also in the Selected Province of Yogyakarta, and East Java, as well as in two districts (Gunung Kidul and Sampang Districts). Furthermore, identified issues pertaining to maternal and child health were analyzed. Prominent issues included barriers in access to maternal and child health, high probability of incidence of unsafe abortion, access to Family Planning services being mostly only to married couples, and medicalization of female genital mutilation/circumcision, which is a form of violence against women. An analysis against the discrepancies in existing laws and regulations that do not meet the Human Rights principles as well as the barriers in policies, strategies and implementation was also undertaken. Based on the results of this field test, a number of recommendations have been committed for priority actions to deal with those barriers as well as mention of stakeholders potentially responsible for following them up.

Lastly, we would like to express our sincere gratitude to all the stakeholders who have financially and substantially provided support to the successful finalization of the document. We hope that our effort will render significant meaning to the improvement of maternal and child health in Indonesia.

Jakarta, February 2007

Director of Maternal Health
Ministry of Health R.I.



Dr. Sri Hermiyanti, MSc.

Foreword by Director General of Community Health, Ministry of Health R.I.

First and foremost, I would like to express my great delight and gratification upon the finalized Report of Indonesia Field Test Analysis on "Using Human Rights for Maternal and Neonatal Health". As we are aware, Indonesia has ratified seven international human rights treaties and possessed Laws that provide protection against basic human rights, such as Law on Human Rights number 39 of 1999.

The Reduction of Maternal and Infant Mortality Rates (MMR and IMR) are two Millennium Development Goals (Goal 4 and Goal 5) agreed upon by a majority of countries worldwide in 2000. The high MMR and IMR has been one of the major concerns, and many efforts have been made to expedite their reduction. One of the efforts has been through the participation in the field test aiming to review and analyze the barriers in policies and regulations that influence maternal and neonatal health as well as the identification of recommendations for action. It is expected that this exercise can trigger improvements in policies and regulations in order to bring significant impacts to the fulfillment of the rights of women and newborns as a part of basic human rights.

At this auspicious opportunity, I would like to thank all the stakeholders who have supported us in the implementation of the field test of the Instrument and in preparing the Report. We expect that the Report could be a starting point to the efforts that ensue to follow up the recommendations by all the related stakeholders in order to meet the right of health of all the peoples especially the women and children in Indonesia.

Jakarta, February 2007

Director General of Community Health
Ministry of Health R.I.

Dr. Sri Astuti Soeparmanto, MSc. (PH)

Introduction

WOMEN'S HEALTH, MATERNAL HEALTH AND HUMAN RIGHTS

The health of women and newborns is central to the development of society. Only women become pregnant and bear children, and the fact that thousands of women around the world continue to die from preventable, pregnancy-related causes represents one of the greatest social injustices of our time. It is now widely recognized and accepted that a preventable maternal death is a violation of women's human rights. Nonetheless, it is estimated that, globally, about 529,000 women die annually from pregnancy-related causes, and that 99 per cent of these deaths occur in developing countries.[1]

In recognition of this, governments of the world agreed to the Millennium Declaration in the year 2000, from which international development goals and targets were set for the world. Of the 8 Goals established, three of them directly concern women's health. Goal number 5 is to improve maternal health, Goal number 3 is to achieve women's empowerment and gender equality, while Goal number 4 is to reduce child mortality. Women's health is critical to all of these. The Millennium Declaration was clearly grounded in human rights. [2]

Human rights have been applied to a wide range of sexual and reproductive health issues, both through the different international treaties that countries have ratified, as well as through national instruments such as the constitution and other laws. One of the reasons progress has been slow in countries where maternal mortality is high, is the lack of attention to creating supportive laws and policies, removing legal and policy barriers that impede the use of life-saving interventions and other necessary services. Human rights provide a framework for governments to take action, and in particular to ensure that their laws and policies are supportive of sexual and reproductive health and do not present barriers. The political, legal and regulatory environment can determine the quality and effectiveness of health services, as well as the extent to which people have access to, and use those services. It also affects other aspects – such as access to information, education and resources – that women need for having safe pregnancies and healthy babies. The effective use of legal and regulatory mechanisms is likely to have an impact on improving maternal and newborn health.

THE MATERNAL AND NEONATAL HEALTH AND HUMAN RIGHTS TOOL

In order to examine legal and regulatory barriers to maternal and newborn health, WHO together with the Harvard School of Public Health have developed a Maternal and Neonatal Health and Human Rights Tool. It aims to create a multi-stakeholder, participatory process that uses a human rights framework to examine the government's actions to meet its human rights commitments to maternal and newborn health made through the international treaties it has ratified and consensus documents it has signed. Such actions may include the examination of laws, elaboration of regulations and of policies, and formulating and implementing standards of care, among others. The Tool is also grounded in the human rights principles of non-discrimination, participation and accountability.

[1]WHO, UNFPA and UNICEF. Estimates of Maternal Mortality in 2000. Geneva, 2003.

[2]Resolution adopted by the General Assembly 55/2. United Nations Millennium Declaration. 2000.

The purpose of the Tool is to help countries to use a human rights framework to identify and address legal, policy and regulatory barriers to women's access to, and use of, maternal and newborn health care services, and to the provision of quality services. The objectives of the Tool are to assist countries to:

- review and address legal, policy and regulatory barriers to maternal and newborn health;
- engage health sector, as well as non-health sector, actors to help eliminate barriers to maternal and newborn health; and
- review and document government efforts to respect, protect and fulfil rights and progress toward achieving international development goals and targets – including the Millennium Development Goals and targets - related to maternal and newborn health.

The Tool consists of both a process (see Annex 1) and an instrument (see map of the instrument in Annex 2). Following human rights principles, the process is participatory in nature, and must involve many different stakeholders. The process is intended to be undertaken by the health ministry as a reflective exercise to strengthen its own maternal and newborn health programmes with technical assistance from WHO and or other partners familiar with human rights and legal and policy issues related to health. It is envisioned that using the Tool takes approximately twelve months depending upon country circumstances and conditions. To coordinate the process and use the instrument, a national project team needs to be established. A resource or research team needs then to be contracted to gather and compile the data required by the instrument. The process requires the active engagement of a multi-stakeholder group which meets early on in the project, and again at the end to discuss the analysis and recommendations.

The Instrument is designed to collect public health data in relation to maternal and newborn health and other aspects of women's reproductive health, along with information on laws and other regulations, policies and health system standards that affect maternal and newborn health. Through the Instrument, these data are compiled according to different relevant human rights. These human rights are grouped together as follows: the rights relating to life, survival and development; the rights relating to health and maternity; the rights relating to education and to information; and the right to non-discrimination.

When the instrument is filled out, the national project team, together with the researchers, conducts an analysis. This consists of identifying gaps and discrepancies in the legal, regulatory, policy and health systems related to specific aspects of maternal and newborn health. Since these gaps and discrepancies are identified within the human rights framework, what emerges in the analysis is the fact that, in order for maternal and neonatal health to be adequately addressed, all the issues identified under all of the rights will need to be given attention (indivisibility of human rights) in the context of the national and international human rights obligations of the country. The analysis also highlights whether laws, policies and programmes are addressing the needs of vulnerable groups, thus systematically identifying whether the right to non-discrimination is protected and fulfilled.

On the basis of the analysis, a draft report is presented to the multi-stakeholder group. This group discusses the analysis and makes and adopts recommendations for multi-sectoral action. The national project team then finalises the report for public dissemination, and the different sectors involved take up the recommendations for implementation.

THE INDONESIA FIELD TEST

In Indonesia, maternal mortality continues to constitute a major concern for the government. The maternal mortality ratio for the period 1998-2003 was estimated to be around 300 deaths per 100,000 live births. While this figure is lower than that estimated for 1990-1994 (390/100,000), it is difficult to conclude that there has been any real decline in the levels of maternal mortality over the past 10-15 years, since the estimates overlap in their confidence intervals. The government recently renewed its efforts with regard to reducing maternal mortality, through the Making Pregnancy Safer initiative. Among the actions laid out by the strategy developed for Making Pregnancy Safer was an examination of the legal and regulatory framework affecting maternal health, to ensure that laws and policies are supportive of, rather than a hindrance to, the reduction of maternal mortality and the improvement of maternal health – one of the Millennium Development Goals.

It was therefore very timely when, in May 2004, colleagues from WHO in Geneva and the WHO Indonesia country office approached the Ministry of Health of Indonesia to conduct a field test of the newly elaborated Tool. At the time, the WHO team met with a number of key stakeholders, including the Ministry of Justice, the Ministry of Women's Empowerment, the Commission on Human Rights, the Commission on Violence against Women, health professional associations and non-governmental organizations. There was great interest for conducting the field test, and WHO and the Ministry of Health started to plan for its undertaking.

The field test was planned to begin in early 2005, but the devastation of the Tsunami overtook all other initiatives, so that it was only in May 2005 that the National Team was put in place and the researchers identified. There were two research teams: one focusing on the public health data, and one focusing on the legal and policy data. (Members of the National Team are listed at the front of this document.) It was also decided at that point to include two districts and their provinces in the field test. These were: Sampang/East Java and Gunung Kidul/Jogjakarta. Thus, it was planned to compile data for both the national level and for the two "pilot" districts.

The first multi-stakeholder meeting took place in August 2005. It was opened by the Minister of Health and included representatives from the various government ministries, from professional associations, from research institutions, from non-governmental organizations, from United Nations agencies, from bilateral donor agencies and from the districts and provinces selected. At that meeting, key health issues were identified as needing particular attention, and suggestions were made as to how the instrument might be adapted to the particularities of the Indonesian situation. Multi-stakeholder meetings were also held in each of the two chosen districts, at which key provincial level stakeholders were also present. Each of these meetings raised topics that are specifically important for the district in question. They also allowed the research team to identify potential sources of data collection.

Data compilation then took place from September 2005 to May 2006. The research teams cast a wide net to bring together all relevant data, and they visited each of the districts and their provincial capitals at least once. This time line was longer than had been anticipated, since it was more difficult than expected to actually obtain all the data required by the instrument.

As explained above, the instrument is organized under a series of human rights related to maternal and neonatal health. From May to July 2006, the National Team conducted a detailed analysis of the data under each right and group of rights. For each right, three elements were identified: key health

issue (or issues); specific vulnerable groups; and a review of the laws and regulations the Government of Indonesia has put in place to support women's health, and of the extent to which such laws and regulations have been implemented. The laws and policies were reviewed in terms of harmonization and discrepancies between the legal and regulatory framework (and/or other aspects of government effort such as standards and protocols in the health system) and the international human rights treaties that Indonesia has ratified.

The results of this analysis were presented to the Final Stakeholder Meeting which took place in September 2006. The same constellation of stakeholders was present at this meeting as at the first meeting. The content of the report was discussed, and the group agreed upon the recommended actions to be taken by the various different stakeholders.

The current report summarizes the analysis and reflects the outcomes and agreements of the Final Stakeholder Meeting. It outlines the international human rights agreements that Indonesia has committed itself to, thus setting the scene against which this analysis is made. It then examines the ten priority health-related issues identified by the National Project Team in terms of:

(1) Health-related considerations;
(2) International human rights standards;
(3) Government efforts;
(4) Discrepancies in laws regulations, policies, strategies and their implementation.

On the basis of these four sections, it makes:

(5) Recommendations for action.

Finally, it summarizes the findings related to especially vulnerable groups, since the human rights framework and principles, as they relate to health, call for specific effort to be taken to ensure that no-one is discriminated against in terms of access to health information and services.

Indonesia's human rights commitments

2

Of the seven international human rights treaties,[3] Indonesia has ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on Torture and the International Convention Elimination of all forms of Racial Discrimination. All of these treaties call on governments to eliminate discrimination on the ground of sex (or discrimination of any kind) and some of them specifically condemn discrimination against women in all its forms.[4] This includes adopting appropriate legislative and other measures, and modifying or abolishing existing laws, regulations, customs and practices which constitute discrimination against women.[5]

The rights that are related to reproductive health include (among others): the right to life, survival and development, the right to the highest attainable standard of health, the rights to education and to information, and the right to non-discrimination. Many of these rights are guaranteed in more than one of the treaties.[6] International human rights treaties become legally binding when governments ratify them. This means that governments must then ensure that their national laws, polices and practices do not conflict, and are consistent, with their obligations under international law and that they respect, protect and fulfil the right to health and other human rights.[7] When a government ratifies a treaty, it agrees to submit reports on a periodic basis on the compliance of domestic standards and practices with the human rights enshrined in the particular treaties. These reports are reviewed by committees that monitor the application of human rights treaties (one committee per treaty - see chart below). The committee then issues concluding observations and recommendations which should be implemented by the government in question. The Government of Indonesia has submitted a number of reports, most notably to Committee on the Rights of the Child and the CEDAW Committee,[8] and has received recommendations from the Committees.[9] These recommendations are incorporated into the analysis below.

[3]The seven international treaties are: Convention on the Elimination of all forms of Racial Discrimination (in force 4 January 1969, ratified by Indonesia with Decree No. 29 of 1999); the International Covenant on Civil and Political Rights (in force 23 March 1976, ratified by Indonesia with Decree No. 12 of 2005); the International Covenant on Economic, Social and Cultural Rights (in force 23 March 1976, ratified by Indonesia with Law No. 11 of 2005); the Convention on the Elimination of Discrimination Against Women (in force 3 September 1981, ratified by Indonesia with Decree No. 7 of 1984); the Convention Against Torture (in force 26 June 1987, ratified by Indonesia with Decree No. 5 of 1998); the Convention on the Rights of the Child (in force 2 September 1990, ratified by Indonesia with Presidential Decree No. 36 of 1990); International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (in force 31 October 2003).They are all derived from the Universal Declaration of Human Rights, agreed to in 1948. See Question and indicator guide Page XXX.

[4]Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child article 2(1); the International Covenant on Economic, Social and Cultural Rights articles 2 (2), 10, 12; the International Covenant on Civil and Political Rights, the International Convention on Torture and the International Convention Elimination of all forms of Racial Discrimination article 1.

[5]CEDAW (Article 2).

[6]Cook RJ, Dickens M and Fathalla MF. Reproductive health and human rights: integrating medicine, ethics and law. Oxford: Clarendon Press. 2003.

[7]Committee on Economic, Social and Cultural Rights, General Comment 14; Committee on the Rights of the Child, General Recommendation 3; International Covenant on Civil and Political Rights; ICPD Programme of Action; Beijing Platform for Action paragraph 107.d.

[8]CEDAW/C/IDN/2-3 (1997); CEDAW/C/IDN/4-5 (2005); CRC/C/3/Add.10 (1992); CRC/C/3/Add.26(1994);CRC/C/65/Add.23 (2002).

[9]CEDAW A/43/38 (1988); CEDAW A/53/38/Rev.1 (1998); CRC A/49/41 (1994)¨; CRC A/51/41 (1996); CRC/C/15/Add.223 (2004).

Key Human Rights Treaties and their Monitoring Committees

Human Rights Treaty	Committee
International Covenant on Civil and Political Rights	Human Rights Committee
International Covenant on Economic, Social and Cultural Rights	Committee on Economic, Social and Cultural Rights
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Committee on the Elimination of Discrimination against Women (CEDAW Committee)
Convention on the Rights of the Child	Committee on the Rights of the Child
International Convention on the Elimination of All Forms of Racial Discrimination	Committee on the Elimination of Racial Discrimination
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment	Committee against Torture
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Committee on Migrant Workers

The Government of Indonesia has also made a commitment to major international consensus documents and development goals that recognize maternal mortality cannot be reduced and reproductive health cannot be improved without the respect and protection of reproductive rights, enshrined in international, regional and national laws. These consensus documents include the International Conference on Population and Development, Programme of Action, (ICPD Programme of Action, 1994), the Platform for Action of the Fourth Conference on Women (Beijing Platform for Action, 1995), the Millennium Development Declaration (2000), United Nations General Assembly Special Session on HIV/AIDS (UNGASS on HIV/AIDS, 2001) and the United Nations General Assembly Special Session on Children (UNGASS on Children, 2002). The various reports submitted by Indonesia in connection with these consensus documents describe the effort made by the Government to improve reproductive health.

These various reports to the treaty monitoring committees and the United Nations describe how the Government of Indonesia has made a significant effort over the past years to enact laws related to women's rights, and to amend and revise laws that were not in accordance with the Constitution and did not respect and protect internationally-agreed human rights standards. However, discrepancies in the legal system still exist in connection with women's issues, specifically with maternal and neonatal health. As the CEDAW Committee expressed in its latest Concluding Comments (1998), "the Committee is very concerned at the existence of laws that are not in accordance with the provisions of the

Convention. It notes that discrimination against women exists in laws regarding: family and marriage, including polygamy; age for marriage; divorce; economic rights, including health and other benefits in the labour sector; health, including the requirement that the wife obtain her husband's consent with regard to sterilization or abortion, even when her life is in danger."[10]

The Indonesian Constitution, and several national laws such as the Law on Human Rights, the Law on Child Protection, the Law on Domestic Violence adopted the principles of international human rights treaties and commitments, setting a clear national framework for their protection.

The Government has also elaborated policies, strategies, plans and programmes on maternal mortality reduction including the improvement of access to skilled birth attendance, making family planning services available, reducing early marriage, and on improving birth registration. However, as the Indonesian report on progress towards attainment of the Millennium Development Goals (2004) points out, the target for the reduction of maternal mortality is very far from being achieved by Indonesia.[11]

[10](Concluding Comments of CEDAW 1998, CEDAW A/53/38/Rev.1 (1998)).

[11]UNDP. Indonesia Progress Report on the Millennium Development Goals. 2004.

Priority health related issues and government accountability in the context of international human rights laws and standards

3

On the basis of the extensive information gathered together and compiled in the instrument, the National Team identified key health-related issues which are critical to women's health and specifically to maternal and newborn health. Under each health issue, international human rights standards were identified, as they relate to the specific health problem. The analysis then highlighted a number of discrepancies under each health issue, where laws or regulations do not meet with international standards. Discrepancies identified in connection with laws include discriminatory provisions of specific laws, contradictions among laws and/or with Constitutional provisions, lack of application of national laws to local regulations or lack of legal protection of certain crucial health issues.

Barriers in policies, strategies, plans and implementation were then identified. Such barriers include inadequacies in the existence of policies, strategies and plans, or in the provision of health services, or in the lack of adequate implementation of policies and plans. Sometimes the barrier identified was the lack of adequate data concerning a particular health problem (though not a policy as such). This constitutes a barrier, since in order to address the different dimensions of sexual and reproductive health problems comprehensively, it is essential to have adequate, up-to-date and reliable data. Without such data, the government cannot accurately monitor the situation nor propose what measures should be taken to eliminate the problem.

Each piece of the analysis leads to recommendations for action, which are proposed under each priority health-related issue. It should be noted that the order of the issues listed below does not reflect any particular priority. They are all considered important by the National Team.

3.1 Early pregnancy, early marriage and adolescents' access to sexual and reproductive health information, education and services

3.1.1 Health related considerations

Marriage at an early age is likely to lead to early childbearing, with its attendant, well-documented, high risks for both mother and newborn. Where childbearing is postponed, health outcomes for both women and their newborns are clearly better.

In Indonesia[12]:

- There has been a steady increase in the age at first marriage over the past two decades, with more educated women marrying at later ages than younger, less educated women Since 1991, the median age of marriage has increased from 17 to 19 years. Nonetheless, marriage of girls 15 years and younger is still practiced in Indonesia, especially in the rural areas, and early childbearing varies considerably from province to province.
- A parallel improvement has occurred in the proportion of women giving birth age 15 or younger, with the current estimates showing only 1 percent versus 7 percent 30 years ago.
- The percentage of women age 15-19 years who began childbearing in 2002-03 was still 10.4 percent.
- There is a substantial difference in fertility among adolescents who live in urban and rural areas. In rural areas the proportion of adolescents who have started childbearing is twice the proportion in urban areas (14 and 7 percent respectively).

[12]Data from this section are taken from the Indonesian Demographic and Health Survey, 2002-2003, and the Indonesia Young Adult Reproductive Health Survey 2002-2003, Macro-DHS, 2003.

- Women with less education are more likely to have begun childbearing during adolescence than women with higher education. While 14 percent of women- with no formal education have become mothers, only 4 percent of women with secondary or higher education have done so.
- Evidence also shows that unmarried adolescents are unable to access the services they need with regard to their reproductive health.
- Knowledge of adolescents about reproductive health and sexuality is still low. For example less than half of adolescents know the human reproduction process, and less than 30 percent of adolescents know how to avoid HIV/AIDS.

3.1.2 Human rights considerations

Governments, through international treaties and consensus documents as well as through their Constitutions and other national laws, agree to protect and promote the rights of adolescents to reproductive health education, information and care.[13] Governments also agreed on the design and implementation of programmes with the full involvement of adolescents, as appropriate, to provide them with education, information and appropriate, specific, user-friendly and accessible services, without discrimination, to address effectively their reproductive and sexual health needs, taking into account their right to privacy, confidentiality, respect and informed consent. Governments also recognized the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child and in conformity with the CEDAW and ensuring that in all actions concerning children, the best interests of the child are a primary consideration.[14]

The Committee on the Rights of the Child in its concluding observations to Indonesia noted the establishment in 1999 of the Commission on Reproductive Health, to deal, inter alia, with the problems of adolescent health, HIV/AIDS prevention and family planning. The Committee was nevertheless concerned that these issues remain a problem for adolescents and that no organized system of reproductive health counseling and services, nor education on HIV/AIDS and sexually transmitted infections (STIs) for youth exists. The Committee recommended to the State:

- to develop comprehensive policies and plans on adolescent health, taking into account the Committee's general comment No. 4 (2003) on adolescent health and development;
- strengthen the implementation of the recommendations of the Commission on Reproductive Health, and promote collaboration between State agencies and NGOs in order to establish a system of formal and informal education on HIV/AIDS and STIs and on sex education;
- take into account the Committee's general comment No. 3 (2003) on HIV/AIDS and the rights of the child and the updated International Guidelines on HIV/AIDS and Human Rights in order to promote and protect the rights of children infected with and affected by HIV/AIDS;
- ensure access to reproductive health counseling and information and services for all adolescents; The Committee was also concerned that despite the Committee's previous recommendation, the legal age of marriage of females (16) and males (19) is still discriminatory. The Committee also expressed

[13]CRC, ICPD, CEDAW, GC 4 CRC, GC 24 CEDAW, CESCR, GR 14 CESCR.

[14]Beijing Plus Five, 2000. Paragraph 79 (f).

its concern that a very large proportion of children, especially girls, are married by the age of 15, and that they are thereby legally considered to be adults, meaning that the Convention no longer applies to them. The Committee recommended that the State party review the age limits affecting children set by different legislation in order to ensure that they conform to the principles and provisions of the Convention. The Committee also specifically recommended that the State party:

- Ensure that no discrimination based on sex remains, and that the age of marriage for girls is the same age as that for boys;
- take all other necessary measures to prevent early marriage;
- Undertake awareness-raising campaigns on the harm and danger resulting from early marriage.[15]

3.1.3 Government effort

The Indonesia Young Adult Reproductive Health Survey 2002-2003 reports that "family planning services that are available to adolescents offer a wide range of information, education, and counselling. However, provision of contraceptive methods to unmarried persons is not part of the national family planning programme."

Recently, the Government started to implement an adolescent reproductive heath (ARH) programme. The goal of the programme is to prepare responsible adolescents in terms of reproductive health behaviour. The programme focuses on giving information and counselling for adolescents on reproductive health matters. In the government sector, the adolescent reproductive heath programme is mainly implemented by BKKBN, Ministry of Health, Ministry of National Education, Ministry of Religious Affairs and Ministry of Social Affairs. For example, the Ministry of Health focuses on preparing health centres as referral centres while BKKBN focuses on empowering adolescent through community groups. This kind of programmes previously was integrated in the family planning programme. Furthermore, adolescent reproductive health is part of the national reproductive health policy and strategy which covers communication and counselling and provision of services.[16] Adolescent friendly reproductive health services is being implemented through Youth Friendly Health Care in a few centres on a pilot basis and Youth Friendly Health Services are being introduced into the community in limited areas.

Increasing teenage pregnancy rates have prompted non-governmental organizations to provide reproductive health information and services to young people. In collaboration with PKBI (the family planning association), and BKKBN, UNFPA supports the production of educational materials to reach parents, policymakers, and community leaders promoting the message "sex before marriage is not appropriate among youth".[17]

3.1.4. Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Unequal provision on age of marriage and inadequate protection of girls/women from early marriage

[15]CRC/C/15/Add.223. 2004. Para 26.27.

[16]National reproductive health policy and strategy, 2005, launched by the Ministry of Health, Sate Minister of Women Empowerment, Ministry of Social Affairs, Ministry of National education and BKKBN.

[17]UNFPA 2000, cited in Indonesia Young Adult Reproductive Health Survey 2002-2003, Macro-DHS, 2003.

The Law[18] on Marriage which sets the marriageable age at 19 for men and 16 for women is contradictory to international obligations on the elimination of child marriage especially the provisions of CEDAW and the Convention on the Rights of the Child that consider early marriage and early pregnancy as a harmful practice. Additionally, in the context of equality between women and men, the CEDAW calls states to take appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular that women have the same right to enter into marriage as men. Furthermore, the Convention on the Rights of the Child sets the minimum age of marriage at 18 years equally for girls and boys. All these principles are translated into the Child Protection Law that considers anyone below 18 to be a child and requires the parents to be responsible and accountable for preventing under-age marriage (Article 26).That is why the Law on Marriage is contradictory to international commitments and national laws that require equal rights to enter into a marriage and sets the minimum age of marriage at 18 years equally for girls and boys.

An other discrepancy is found between the Law on Marriage and the Child Protection law with regard to consent. While the Law on Marriage requires parental consent to marry from those who have not reached 21 years, (Article 6, Paragraph: (2)) the Child Protection Law considers people to be children below the age of 18. That is why the Marriage Law is in contradiction with the Child Protection Law and the Convention of the Rights of the Child that defines children up to 18 years.

Polygamy

The other discrepancy found in the Law on Marriage (Law Number 1 of 1974 Article 3) relates to polygamy. Although the Law states that a man must have only one wife and a woman must have only one husband, it also states that the court may grant permission for a husband to have more than one wife if it is desired by the parties involved. This permission for a husband may be granted if the wife "cannot perform her duties as a wife, if she is physically disabled or suffers from an incurable illness, or if she is unable to have children." This Law is contradictory to several international treaties, the Law on CEDAW (Law No.7 of 1984 on CEDAW (Article 1), the Law (No.39 of 1999) on Human Rights (Article 3 paragraph 3), as well as the Constitution (Article 28B paragraph 2), all of which protect the right to be free from discrimination. The above cited provisions of the Law on Marriage undermines women's status in the society and this may have a direct or indirect impact on women's health and access to health services.

Inadequate legal protection for unmarried adolescents in relation to reproductive health services

International human rights treaties, as well as consensus documents such as the Programme of Action of ICPD and the Platform for Action of FWCW ratified and signed respectively by Indonesia, call upon the government to provide services that are available, accessible, affordable and of good quality for all segments of the population without discrimination. The ICPD Programme of Action agreed that individuals or couples have the right to decide freely and responsibly the number and timing of their children, and to have the information and means to do so free of discrimination, coercion and violence. Despite the fact that international commitments of the State call for the protection of everyone's - and specifically adolescents' – sexual and reproductive health without discrimination including provision of services, the Population Law

[18]Law No. 1 of 1974 on Marriage, Article 7 Paragraph (1).

allows family planning services only for married couples. This means that unmarried adolescents who are not able to get access to contraceptives may be exposed to unintended pregnancy and are likely to seek an induced abortion that is often carried out in unsafe circumstances. Because of the restrictive nature of abortion, this is likely to be carried out by an unqualified provider in unsafe conditions, thus presenting a high health risk.

This is why the specific provision of the Population Law that allows only married couple to have family planning services, might be contradictory to the Constitution (article 34.(3), the Law on Human Rights (Article49.(3), Article 62, the Child Protection Law (article 18), the Health Law (Article 4) and the Law on CEDAW (Article 12) all of which call for the provision of adequate health services and facilities to everyone without discrimination.

Furthermore, it also contradictory to the provisions of Convention on the Rights of the Child and the Child Protection Law that calls for the protection of the right to health of the child including those up to the age of 18. According to the official interpretation of the Convention in the context of adolescents health and development, States should develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) develop policies that will allow adolescent mothers to continue their education.[19] The Child protection law in accordance with the Constitution and the Convention of the Rights of the Child enshrines that every child shall have the right to healthcare services and social security in accordance with his physical, mental, spiritual and social needs.

The Government initiated steps to develop programmes that provide counselling and information on reproductive health for adolescents. However none of these provide contraceptive services, only information and education.

Barriers in policies, strategies, plans and implementation

In order to delay early marriages, the government (reflected in the BKKBN policy) promotes later marriage for both women and men. However, it recommends a minimum age for marriage of 21 years for women and 24 years for men. This policy contradicts CEDAW which requires equal rights for women and man to marry and found a family.

The Commission on Reproductive Health which was established by the Ministry of Health in 1996 is not functioning well. In 2006 the Ministry of Health started to reinforce the function of the Commission.

The establishment of adolescent friendly services in Indonesia is still in a pilot phase and does not constitute a programme disseminated all over the country.

For adolescent sexual and reproductive health information and services, national and provincial level implementation plans appear to be either lacking or inadequate. There are no standards for youth centres, training of peer educators and peer counsellors nor an accepted minimum content for reproductive health and sexuality information given to adolescents.

The primary focus of information and counselling for adolescents on reproductive health is on morality and abstinence. The content of IEC and counselling is not adequate to protect adolescence from RH and sexuality problems.

[19]General Comment No. 4. Adolescent health and development in the context of the Convention on the Rights of the Child. Committee on the Rights of the Child, thirty-third session, 2003.

3.1.5 Recommendations for priority actions

Legal and regulatory measures

- The existing Law on Marriage should be revised in order to eliminate early marriage and early pregnancy by defining the minimum legal age of marriage in 18 for both women and men. Consent from the parents for marriage may be required up to 18 years.
- The provisions of the Law on Marriage, (Law Number 1 of 1974 Article 3) that give authority to the court to grant permission for a husband to have more than one wife if it is desired by the parties involved and especially if the wife "cannot perform her duties as a wife, if she is physically disabled or suffers from an incurable illness, or if she is unable to have children", should be eliminated.
- Both the Law on Population and the Law on Health should be amended and revised to make comprehensive reproductive health services including contraceptive services available, accessible, and affordable for unmarried women and men, including adolescents.

Those potentially responsible: The Ministry of Women's Empowerment, the Ministry of Education, Ministry of Religious Affairs and the Ministry of Law and Human Rights, BKKBN.

Policies, strategy, health system measures

- Policies and strategies should be developed to empower adolescents and young people with sexual and reproductive health and rights knowledge, understanding and skills and on the provision of adolescent's friendly services.
- Policies regarding the promotion of minimum age of marriage for women and men should be harmonized.
- The Commission on Reproductive Health should be revitalized with the participation of various stakeholders and should include young people.

Those potentially responsible: The Ministry of Health and the Ministry of Women's Empowerment, in coordination with the Ministry of Education, the Ministry of Religious Affairs, the BKKBN.

3.2 Family planning: inaccessibility of contraceptive services for unmarried people, husband authorization to seek services, and lack of comprehensive knowledge about contraceptive methods

3.2.1 Health related considerations

Delaying and spacing births through the use of effective contraception has long been recognized as essential for women's reproductive health and for the health of their offspring. Effective use has many elements, such as that users should be given adequate information in order to make an informed, voluntary choice of a contraceptive method, that service providers must be trained in providing family planning counseling to help users make informed and voluntary decisions about their fertility. Contraceptive choice is in part also dependent on the effectiveness of the contraceptive method in preventing unplanned pregnancy and adequate and appropriate equipment and supplies need to be maintained and held in stock. Effective contraception includes emergency contraception which has a significant impact in preventing unwanted pregnancies and abortions.[20]

[20]Medical Eligibility Criteria for Contraceptive Use. WHO. Third edition 2004. Available at: http://www.who.int/reproductive-health/publications/mec/index.htm

Contraceptive prevalence in Indonesia has greatly increased over the past 30 years, and contraceptive methods are being used for both postponing and spacing births by around 60 percent of married women.[21] Knowledge of at least one contraceptive method is almost universal among men and married women.

However[22]:

- There is a serious lack of data concerning the access of unmarried people, particularly adolescents, to information and services for contraception. The level of knowledge among young people on contraception is still low. The family planning programme makes services available only for married couples. The adolescent reproductive health programme for unmarried young people age 10-24 years focuses only on moral issues and abstinence.
- Unmet need for contraception is 8.6 percent.
- Among women giving birth, 9.6 percent would have preferred the pregnancy at a later time and for 7.2 percent the pregnancy was unwanted. Among women who have used contraception, 21 percent chose to discontinue within 12 months after beginning its use.
- The availability of emergency contraception is not widespread yet since, although it is part of the Government programme, there is as yet no systematic IEC provision and BKKBN does not include emergency contraception in its logistic procurement programme.
- Less than a quarter of current contraceptive users are informed about side effects and the possibility of changing to other methods. Women who are sterilized are the least likely to be informed about the effects of the method.
- Use of family planning is virtually the same in urban and rural areas (61 percent and 60 percent respectively), but use of contraception increases with an increase in a woman's level of education. It also increases with higher wealth index quintile, from 52 percent for women in the lowest quintile to 64 percent for those in the highest.
- Male participation in family planning is very low, consisting of 0.9 percent for condom and 0.4 for male sterilization.

3.2.2 Human rights considerations

Rights relating to reproductive self determination and free choice of maternity have been developed through interrelated rights, including the right to decide the number and spacing of one's children, the right to privacy and to family life, and the right to marry and found a family. Furthermore, the availability, accessibility (including affordability, and accessibility of information) and quality of reproductive and sexual health services, are recognized not only as a key intervention for improving the health of men, women and children, but also as a human right to the highest attainable standard of health. These rights are enshrined in various human rights treaties and consensus documents ratified and signed by Indonesia.[23] They are also enshrined in the Constitution of Indonesia, and other national laws such as the Law on Human Rights, Law on CEDAW and the Health Law.

Free choice of maternity is increasingly recognized as an attribute of private and family life, in order that individuals may decide whether, when and how often to have children, without control and coercion by

[21]Indonesia Demographic and Health Survey 2002-2003.

[22]Data for this section taken from the Indonesia Demographic and Health Survey 2002-2003 and the Indonesia Young Adult Reproductive Health Survey 2002-2003.

[23]Article 12 CESC, GC 14, CRC, CEDAW, CESC.

the government or third parties. (Governments may propose to influence reproductive choices through incentives, but cannot apply compulsion or coercive means). Treaty monitoring bodies, such as the CEDAW Committee, the Committee on the Rights of the Child and the Human Rights Committee, have shown concern over laws in several countries that require husband's authorization for women to access family planning methods. They have asked particular states to eliminate requirements for parental consent in an effort to make health services, including reproductive health services, more accessible for adolescents, and asked for women's free and informed consent with respect to contraception.[24]

3.2.3 Government effort

A comparison of the findings from the Indonesia Demographic and Health Surveys of 1997 and 2002-2003 indicate that there has been an improvement in the percentage of family planning needs fulfilled. Based on the same data, the outreach of family planning services to the community has also increased.

The national family planning policy, based on Law No. 10 on Population, is being widely applied and implemented. However, although the policy does allow the provision of information to unmarried people, it does not allow the provision of services. To achieve quality of life of families by 2015 *(Keluarga berkualitas; paradigma baru),* it stresses raising the age of marriage, regulation of fertility (number of pregnancies) combined with income generating activities, and improving the quality of care in services.

The current government policy focuses on maximizing access and quality of family planning services. Among the activities there are: improving quality of the training of family planning providers in midwifery schools (pre service training approach) and in-service training of midwives and other family planning providers; integrating family planning services into the health insurance system for the poor, further encouraging the private sector to provide contraception in remote areas; and starting to promote emergency contraception by training.. The MOH in collaboration with POGY (Indonesian OBGYN Association) elaborated guidelines on emergency contraception, however they are not fully disseminated and implemented yet.

3.2.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Inadequate legal protection for unmarried women in relation to reproductive health services (see also 3.1.4)

As it is pointed out under section 3.1.4, the population Law allows family planning services only for married couples. This means that unmarried women who are not able to get access to contraceptives may be exposed to unintended pregnancy and are likely to seek an induced abortion. As it is mentioned before, because of the restrictive nature of abortion, this is likely to be carried out by an unqualified provider in unsafe conditions, thus presenting a high health risk. This is why the specific provision of the Population Law that allows only married couples to have family planning services, might be contradictory to the Constitution, the Law on Human Rights, the Law on CEDAW and the Health Law all of which call for the provision of adequate health services and facilities to everyone without discrimination.

[24]Bringing Rights to Bear :An Analysis of the Work of U.N. Treaty Monitoring Bodies on Reproductive and Sexual Rights. Center for Reproductive Rights and University of Toronto International Programme on Reproductive and Sexual Health Law. 2002.

Husband authorization for women to have access to reproductive health services

As mentioned above, international human rights treaties and consensus documents ratified/ signed by Indonesia recognize individuals' basic human rights related to free choice of maternity. The Population Law number 10/1992 Article 17 requires that "husband and wife must agree on birth regulation and the method that will be used", and the practice of requiring the husband's authorization for a married woman to receive contraception and sterilization is contradictory to the principles of international law and consensus documents ratified and signed by Indonesia. These treaties, and agreement s states that individuals may decide whether, when and how often to have children, without control and coercion by the government or third parties. Although at the International Conference on Population and Development in 1994 Indonesia supported the position that family planning is for couples not for individuals, it did not make reservations to the Beijing Platform for Action or to CEDAW and other Treaties in this regard. The Population Law also contradictory to the Law on Human Rights (Article 49 (3)) which states that "the special rights to which women are entitled arising from their reproductive function are guaranteed and protected by Law."

Discrepancy in the Criminal law with regard to family planning information

The Criminal Code forbids the showing in public of materials, contraceptive devices and pictures of the anatomy of women and men, and to provide information on termination of pregnancy. This might be contradictory to the provisions of CEDAW, as well as to the provision of the Law on Population and Family Welfare, that states, "in order to encourage the small, happy and prosperous family norm, the government shall implement improvement in: (a) education, development, and/or services on spacing of births; (b) provision of facilities and infrastructure that are required for pregnancy spacing services; (c) counselling to determine the best age to enter marriage and give birth."[25]

Barriers in policies, strategies, plans and implementation

The Government initiated steps to develop programmes that provide counselling and information on reproductive health for adolescents. However, none of these provide contraception services, but only information and education.

Current implementation activities related to the provision of family planning give inadequate emphasis to the importance of men's use of contraception (only 1 percent contraceptive prevalence nationally).

Inadequate attention is paid to *giving full and accurate information* about the different methods of contraception available (especially to women who are sterilized, since nearly 20 percent are not aware that sterilization is a permanent method).

The Ministry of Health has developed guidelines and provided training in emergency contraception in some provinces, but IEC on emergency contraception and the provision of the service is not yet routinely available in the health facilities.. Hormonal emergency contraception is not included in the national essential drugs list, despite the fact that it is included in the WHO Model List of Essential Medicines.

[25]Law No. 10 of 1992 on Development of Population and Family Welfare, Article 23 Paragraph (1).

3.2.5 Recommendations for priority actions

Legal and regulatory measures

- The accessibility and affordability of contraceptive services for unmarried people has to be assured as an integral part of the amendment of the Health Law.
- Access to family planning services for the unmarried people (as well as married people) should be ensured and being integrated into the ongoing process of the amendment of the Population Law.
- Requirement of husband authorization for women to use birth regulation and what type should be eliminated and the Population Law should be amended in this regard.
- The provisions in the revised Criminal Code that "forbids the showing in public of materials, contraceptive devices and pictures of the anatomy of women and men, and to provide information on termination of pregnancy" needs to be eliminated.

Those potentially responsible: The Ministry of Health, BKKBN, the Ministry of Law and Human Rights, professional associations, Ministry of Manpower.

Policies, strategies, health system measures

- Partnerships between the Government and the private sector should be fostered in order to raise the contraceptive knowledge of and use by unmarried people and adolescents, especially those who live in remote areas.
- Reproductive health services, that includes family planning, should be provided for unmarried people and adolescents.
- The provision of comprehensive information on contraceptives and informed choice for all must be reinforced.
- The Government programme on male participation/ involvement in family planning, which consists of both information and services, must be strengthened.
- At central, provincial, district and service levels, improve and foster the coordination between BKKBN and MOH in planning and implementing intervention at all levels.

Those potentially responsible: The Ministry of Health, BKKBN, professional associations.

3.3 Access to services for pregnancy, childbirth, and the postpartum

3.3.1 Health related considerations

A strong body of evidence shows that women who attend antenatal care and who have skilled attendance at delivery (either in a health facility with an emergency unit or with a skilled provider who is linked to a functioning referral system) and during the postpartum period have a better chance of surviving the unexpected complications of labour and birth than those who do not. Among the key life-preserving interventions during antenatal care, for instance, is the provision of malaria prophylaxis, tetanus toxoid immunization and the diagnosis and treatment of anaemia and syphilis. Malaria is a serious health risk to pregnant women and newborns; it is a major cause of maternal anaemia and of low birth weight. Syphilis is a chronic infectious disease usually transmitted by sexual contact or from mother to infant.

In Indonesia, the following issues were identified:

Antenatal care and delivery

- Maternal mortality is still very high in Indonesia where only around 20 percent of community health centre offer Basic emergency obstetric and neonatal care (BEONC) and 80 percent

of public hospitals offer irregular CEONC (Comprehensive Emergency Obstetric and Neonatal Care). There are limited reported data on the existence of referral systems for emergency obstetric and neonatal care, particularly in rural areas, but anecdotic information suggests that the emergency referral is left to individuals to decide.

- At the national level, the proportions of women seeking both antenatal care (ANC) and skilled attendance at birth have improved considerably over the last 15 years. Provision of ANC services should be available at public health centres (Puskesmas, Polindes, Posyandu). However, there is still quite a large gap between rural and urban women in access to both antenatal care and skilled care during childbirth. In certain provinces proportions of women attending ANC have actually dropped over the last five years.
- Women with low or no education are less likely to access ANC and delivery in health facilities than educated women.
- Delivery by skilled birth attendants is less frequent in rural than in urban areas and less common among poor and non-educated women.
- The population based Caesarean section rate is very different in rural (1.1 percent) and urban (6.5 percent) settings, showing impaired access of rural population to emergency services.
- Deliveries are mostly done at home with the assistance of a midwife or a traditional birth attendant especially in rural areas where the referral system is non-existent.
- Malnutrition and anaemia in pregnancy remain a serious and widespread problem, and provision of iron supplementation is poor.

Tetanus, malaria, HIV

- Tetanus and malaria continue to contribute significantly to maternal and newborn mortality and morbidity; tetanus immunization remains low and prophylaxis for malaria is not systematically provided.
- High numbers of still births and increased number of HIV infections in the general population justify systematic screening for syphilis in pregnancy that is not currently part of the ANC programme.
- With regard to screening of blood for HIV, the Indonesian Red Cross, which has been assigned by the Government to manage blood products, has 169 Blood Transfusion Units (out of 440 Districts) or BTU (Report of BTU-RCI, 2005). All of these BTU are supposed to conduct HIV screening routinely (reagents are available and provided to the Red Cross). Some (41) hospitals have their own BTU, usually integrated in the laboratory unit, but there are no reports on the supply of reagents, workload and performance.

Neonatal mortality

- The neonatal mortality rate in Indonesia in 2002-03 was 20 per 1000 births with big variations among the provinces. This figure is higher than the rate in neighbouring countries.

3.3.2 Human rights considerations

International human rights treaties and consensus documents call for the provision of maternal health services. Article 18 of CEDAW, for instance, calls upon States to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning, pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." In addition to these obligations, the Committee on Economic Social and Cultural Rights has issued a General Comment which explains the minimum core obligations of Article 12 on the right to the highest attainable standard of health. It explains that states have core obligations to provide essential primary health care in order to satisfy the

right to the highest attainable standard of health, and confirms that ensuring reproductive, maternal (pre-natal as well as post-natal) and child health care are obligations of comparable priority.[26]

Treaty monitoring bodies, such as the Committees overseeing CEDAW and the Convention on the Rights of the Child have repeatedly expressed their concern about the high maternal mortality in Indonesia. The Convention on the Rights of the Child, in its latest concluding observations in 2004, acknowledged the improvement in budget allocations to the health-care sector, but remained concerned at the high maternal mortality ratio and the proportion of children born with low birth weight. The Committee recommended that the State ensure universal access to primary health care, especially maternal and child health-care services and facilities, including in rural and conflict-affected areas.[27] Furthermore, it has been agreed that Millennium Development Goal 5 can not be achieved without necessarily strengthening the health system, particularly at the district level, with priority given to strategies for reaching the child health and maternal health services. Maternal mortality strategies should include ways to achieve universal access to reproductive health services and the health workforce strategy should include plans for building a cadre of skilled birth attendants. Poverty-reduction strategies and funding mechanisms should support and promote actions that strengthen equitable access to quality healthcare and do not undermine it.[28]

The Constitution and several national laws also provide protection for basic human rights related to accessibility and availability of health services, including reproductive health services. (Health Law, Article 4; Law on Child Protection, Article 44;Law on CEDAW Article 12.) . The Law on Human Rights (article 49) specifically enshrines "special rights to which women are entitled arising from their reproductive function are guaranteed and protected by law."

3.3.3 Government effort

Over the past decade the Government made a significant effort to increase access to professional assistance during prenatal, delivery and postnatal care. In order to reduce maternal and antenatal mortality and morbidity the Ministry of Health launched a national strategic plan on Making Pregnancy safer 2001-2010. The main messages include that every delivery should be assisted by a trained health provider, and every obstetric and neonatal complication should be managed adequately. This strategic plan has become the main instrument for Government planning and project support from the main health partners (donors) as well. To facilitate a comprehensive approach, a strategy for the reduction of neonatal mortality has been developed by the Ministry of Health. Both documents include, as a key intervention, capacity building of obstetric teams in district hospitals and in public health centres for the treatment for the most threatening life complications. (BEONC and CEONC training).

A village midwives programme was launched in 1993 by the Ministry of Health starting with a one year training programme for 52,000 nurses to become midwives. Several steps have been taken by the Government to support the programme and it can be presumed that it has contributed significantly to the improvement of ANC coverage and services, especially in rural areas.[29]

[26]The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) General Comment No. 14. The Committee on Economic, Social and Cultural Rights. 2000. Para 44.

[27]CRC/C/15/Add.223/2004.

[28]Who's got the power? Transforming health systems for women and children. UN Millennium Project. Task Force on Child Health and Maternal Health. 2005.

[29]WHO and Ministry of Health Republic of Indonesia, *Indonesia Reproductive Health Profile 2003.*

However, since 1994 between 20 percent and 40 percent of the midwives have left the programme. According to the evaluation of the programme, the main reasons were: the posting of midwives and the implementation of the programme were done without large community involvement; the condition of *polindes* (a village health post managed by the community)) was very poor; emergency drugs and referral mechanisms to emergency services were not provided; and the quality of the training was inadequate. Furthermore, the programme was designed in a way that after the contract was renewed a maximum of three times (financed by the Government) the midwives should be able to sustain themselves through their private practice in the community. However, this proved unrealistic for many midwives especially in the most remote and problematic areas, while others continued to be funded by district or central level government.[30] As a part of this programme a midwife/traditional birth attendant (TBA) partnership programme was developed to enhance collaboration between midwives and TBAs in order to increase access to safe delivery. After the evaluation of the quality of delivery care provided by the village midwife, the Ministry of Health identified the need for normal delivery and basic emergency obstetric care training for the village midwives and started to implement it with donors' support.

An integrated service post - *Posyandu* - programme was started in the context of the safe motherhood programme announced by the President of Indonesia in 1988 and has continued to date as part of the implementation of the Making Pregnancy Safer Strategy. The aim of the programme is to bring services to the community, including family planning, growth monitoring, immunization and nutrition services. It involves community volunteers as service providers, staff from the referral health centre (puskesmas) and the village midwife.

In 1996 a national workshop on accelerating maternal mortality reduction was launched in response to the recommendation of the Mother Friendly movement. The movement stressed the importance of a multi-sectoral approach towards the attainment of the reduction of maternal mortality and the improvement of the quality of life for women.

The Ministry of Health aims for universal coverage for basic health services, including maternal health services. However, the cost is a major deterrent for people- especially the poor to use services. Current costs of services include not only payment for services but travel costs and time lost for other productive activities. The result is low utilization of the basic public service especially among the poor.[31] In response to the economic crisis, the Social Safety Net Programme was introduced in 1998 by the Government; one of the five components of the programme was free medical and family planning services for the poor at government primary health centres *(puskesmas)* and hospitals. The programme also included free food supplements for pregnant women and for children under three years of age. However, it was found that a substantial percentage (40 percent) of the health cards issued for the poor were owned by the top three quintiles of the population. It was also noted that whereas 18.8 percent of the population was identified as poor in January 1998, only 10.6 percent of Indonesian households reported ownership of a health card.[32] According to evaluations of the programme, two of the main reasons for the relatively weak performance of the Safety Net Programme are: local village leaders often did not adhere to the

[30]The Bidan Di Desa Program. A Literature and Policy Review. Emil Parker, Ambar Roestam. MNH Programme JHPIEGO, 2002.
[31]*(The Millennium Development Goals for Health: a review of the indicators.* WHO Indonesia, 2003).
[32]Final Report on the Health Referral System in Indonesia. WHO, 2005.

list of eligible households; and health providers received lump sum grants from the Government to provide services but when the grants ran out they charged for the services again.[33]

In 2005, the government introduced a health insurance scheme for the poor managed by PT Askes as a continuation of government's previous efforts to cover the cost of health financing for the poor. However barriers are still found related to discrepancies in the numbers of poor families identified by the Central Bureau of Statistics and the local data, lack of awareness raising among the target population about the scheme, and delay in claim process.

With regard to maternity protection, according to the Law on Manpower, female workers and labourers are entitled to rest, starting one and a half months prior to delivery and lasting one and a half months after the birth of the baby.[34] According to Law number 13, 2003 on manpower article 83 "female workers/labourers whose children are still breast fed must be given the opportunity to breast feed their children if it has to be done during working hours."

Provinces and districts have made steps towards the adoption and implementation of the Making Pregnancy Safer Programme to the local level. Activities include: development of a training programme for midwives at the provincial health polytechnics (for instance the Midwifery Diploma III programme in Surabaya Health Polytechnic); and funding for the village midwife programme from the annual provincial and/or district budget (Gunung Kidul).

3.3.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Inadequate legal protection of maternity

The Law on Manpower No. 13 of 2003 has a provision that entitles female workers/ labourers to rest, starting one and a half months prior to delivery and lasting one and a half months after the birth of the baby (Article 82(1)). The provision of this law does not fully apply the principles of the International Labour Office (ILO) convention that requires not less than 14 weeks leave for female employees,[35] and accords paid leave or leave with adequate for working mothers during a reasonable period before and after childbirth.[36] That is why the provisions of the Law on Manpower on maternity protection are not fully in accordance with the provision of international human rights treaties that call on States to ensure women have access to appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary.[37]

Barriers in policies, strategies, plans and implementation

Some of the immediate shortfalls in policy and strategy implementation relate to coverage, particularly for the poor. For instance:

- There is no routine auditing of maternal death done.
- Implementation of the village midwives programme has met with only partial success, and long-term sustainability is a problem. (see 3.3.3).

[33]Policy brief 5: Social Safety Nets. DFID, 2005.

[34]Law on Manpower No. 13 of 2003 (Article 82(1).

[35]ILO Convention, C183 on Maternity Protection, 2000.

[36]ILO Convention C183 on Maternity Protection, 2000; Article 10(2) CESC.

[37]Article 24(d) of CRC; CEDAW Article 12(2) and Article 10(2).

- The system of "health cards" to enable poor people to access services is only partially reaching those in need. (see 3.3.3)
- Despite significant efforts on the part of the Government to provide appropriate legal and regulatory guarantees for the provision of essential medicines, good quality medical supplies (including drugs, equipment and safe blood), are often unavailable, especially at district hospital level. Additionally, the national and provincial level data on the availability of essential medicines, equipment and diagnostics for maternal and newborn health is inadequate.
- While there is an immunization programme coordinated by the Expanded Programme on Immunization and the Maternal and Child Health Care units in the Ministry of Health, no comprehensive national policy, strategy or plan has been developed on addressing congenital syphilis, tuberculosis? and malaria in pregnancy.
- Anecdotal evidence shows that some employers demand marriage certificates from women who have a right to maternity leave, although no national level regulation requires it.[38] This practice discriminates against women who are pregnant and have a child out of wedlock. It is contradictory to international human rights treaties that require maternity protection without discrimination of any kind.

3.3.5 Recommendations for priority actions

Legal and regulatory measures

- The Law on Manpower No. 13 of 2003 harmonized with the ILO Convention, C183 on Maternity Protection, 2000.

Those potentially responsible: Ministry of Health, Ministry of Manpower, Ministry of Women Empowerment

Policies, strategy, health system measures

- Existing laws and regulations such as Law No. 7 year 1984 on CEDAW Article 12 should be implemented more proactively.

- The following should be undertaken with regard to services:
  - Availability of quality maternal health services should be assured. This includes high standard pre-service training for doctors and midwives, recruitment, placement, clear job description and guidance/supervision of all health personnel, minimum standards for health facilities and accessible referral systems according to local needs and situations.
  - Pregnant women recognized as poor should have comprehensive maternal services free of charge.
  - The TBA-midwife partnership should be strengthened, recognizing the fact that a high percentage of pregnancies are still delivered by TBAs.
  - The referral systems need to be strengthened.
  - The availability of free blood screened for syphilis, HIV and Hepatitis B, coordinated by Red Cross Indonesia should be ensured.
- National data collection:
  - A mechanism for systematically undertaking maternal death audits of the original causes which lead to maternal and perinatal deaths should be put in place.
- The Mother Friendly Movement which was officially launched in 1996 should be revitalized.

[38]Evidence presented at a workshop on "Maternity Protection for Female Factory Workers", 16 June 2006, Jakarta, organized by female Trade Unions from East Jakarta.

- With regard to maternity protection
  - The right to paid pregnancy leave, without having to provide a marriage certificate, should be assured.
  - Institutions should guarantee that the time allowance for a woman to breastfeed her baby as recognized in articles 81, 82, and 83 of Law no 13/2003 is implemented to the benefit of the women workers.
  - Mechanisms to monitor the implementation of maternity protection in factories and workplaces should be developed.
- Policy and budget allocations for the poor must be evaluated to ensure the control and possible eradication of all communicable and sexual transmitted diseases such as tuberculosis, malaria, STI, especially HIV, in order to protect women during the pregnancy.

Those potentially responsible: Ministry of Health, Ministry of Women's Empowerment, Central Bureau of Statistics, Ministry of Manpower, Coordinating Ministry of Social Welfare.

3.4 High incidence of unsafe abortion

3.4.1 Health related considerations

A substantial proportion of unwanted pregnancies end in induced abortion, whether or not it is legal and whether or not it is safe.[39] Evidence over the past 20 years indicates that increased access to contraception, non restrictive legal frameworks on abortion, and appropriate guidelines and training for practitioners can significantly reduce rates of recourse to induced abortion, including unsafe abortion, and rates of abortion-related maternal mortality and morbidity.[40] It has been recognized in connection with the achievement of Millennium Development Goal 5, that complications of unsafe abortion are the one category of fatal obstetric complications that could be almost totally prevented through the provision of appropriate services. The world community has repeatedly agreed that where abortion is legal, it should be provided safely and, in all cases, complications of unsafe abortion should be treated promptly through high-quality health services.

In Indonesia, abortion is under reported due to the restrictive nature of the law but the most recent estimates put the figure at around 2 million (both induced and spontaneous). This figure is deemed to be an underestimate. This indicates that there is high unmet need for safe abortion services. Data from the national household health survey in 2001 indicated that complications of (unsafe) abortion contribute to 5 percent of maternal deaths.[41]

Data from 2001 indicate that 24 percent of abortions are performed by traditional birth attendants (ranging from 15 percent in the cities to 84 percent in rural areas).[42]

3.4.2 Human rights considerations

The various human rights treaty monitoring bodies have expressed their concern over illegal and unsafe abortion in the context of the right to life, the right to health and the right to privacy all of which are enshrined in various human rights treaties. The Human Rights Committee characterized high rates of maternal mortality caused by unsafe abortion as

[39]World Health Organization. Unsafe abortion : global and regional estimates of mortality and morbidity. Geneva, 2005. [check]

[40]Who's got the power? Transforming health systems for women and children. UN Millennium Project. Task Force on Child Health and Maternal Health.2005. Abortion Law, Policy and Practice in Transition. Reproductive Health Matters 2004; 12 (24 Supplement): 1-8.

[41]Utomo B. At al. Incidence an social/psychological aspects of abortion in Indonesia. A community survey in ten major cities and six districts, year 2000. Centre for Health research University of Indonesia, Jakarta 001.

[42]Utomo B. At al. Incidence an social/psychological aspects of abortion in Indonesia. A community survey in ten major cities and six districts, year 2000. Centre for Health research University of Indonesia, Jakarta 001.

a violation of women's rights to health and life and recommended that necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the treaties.[43] The Committees have explicitly asked States to review and change legislation criminalizing abortion, and countries agreed that governments and other relevant actors should review and revise laws, regulations, and practices that jeopardize women's health including those related to abortion.[44] Furthermore, as abortion is legal in almost every country for at least one reason, and in three-fifths of all countries to preserve the physical and mental health of the woman, the international community agreed that "health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible".[45]

3.4.3 Government effort

The Making Pregnancy Safer Strategy, which has been guiding the Government's action on maternal mortality since 2001, recognizes unsafe abortion as one of the main causes of maternal mortality, and one of the key messages of the strategy is that every woman should have access to prevention of unwanted pregnancy and management for complications of unsafe abortion. *(National strategic plan on making pregnancy safer in Indonesia, 2001-2010.* Jakarta, 2001). Implementation activities are targeting mainly prevention of pregnancy through family planning, and provision of post abortion care. They do not address the problem of unsafe abortion contributing to maternal mortality and the unmet need for safe abortion services.

Following the survey conducted in 2003 (see reference above), NGOs together with POGI (Indonesian Obstetrics and Gynaecology Association) and hospitals/clinics in 9 big cities started to develop service delivery standards for safe abortion services for cases allowed by law (Article 15 of the Health law).

3.4.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Lack of legal protection for pregnant women in order to save their life in an emergency situation and the lack of recognition of the right to health in connection to abortion

Although several human rights treaties ratified by Indonesia, such as CEDAW, the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights, as well as the Constitution and the Law on Human Rights, require absolute protection for the right to life without discrimination, the Health Law (No. 23, 1992) does not provide clear protection for the right to life of women even in emergency situations. Article 14(1) of that Law says that "in an emergency situation as an effort to save the life of a pregnant woman and/or her foetus, certain medical actions can be conducted". The lack of absolute protection for the right to life of a women in an emergency situation is also contradictory to the official explanation of Article 9 (on the right to life) of the Law on Human Rights (Law 39/1999) that says that, in an extraordinary situation to save the life of the woman, abortion can be performed.

[43]United Nations, Human Rights Committee. *Concluding Observations on Peru:11/18/96.* UN Doc. ICCPR/C/79/Add.72 at para. 15.19.22.

[44]Beijing Platform for Action, para 96.

[45]ICPD+5 paragraph 63iii.

Furthermore, deliberate termination of pregnancy is considered a crime under the Criminal Code (Article 346-348). Denying services that women need in order to save their lives and health is contradictory to the Constitution that protects the right to life and health, and also to international human rights standards.

Barriers in policies, strategies, plans and implementation

In view of the legally restrictive nature of abortion, health care providers are unaware of the grounds on which abortion can be provided within the current law. Also there is a lack of training for providers in methods of safe abortion.

Data is needed to measure the magnitude of unsafe abortion as well as abortion complications contributing to maternal morbidity and mortality, so that policies and programmes may be put in place to address the problems.

3.4.5 Recommendations for priority actions

Legal and regulatory measures

- The formulation of the new Health Law regard to abortion should reflect international human rights standards related to the protection of women's lives and health and public health needs of women who may have unwanted pregnancies and may die due to the complications of unsafe abortion.
- The Criminal Code needs to be revised in order to decriminalize women who seek abortion services. The Criminal Code also needs to be revised in order to decriminalize medically qualified providers who provide safe abortion services when the law allows.

Those potentially responsible: The Ministry of Health, the Ministry of Law and Human Rights, Ministry of Religious Affairs, Parliamentarians, professional associations,

Policies, strategy, health system measures

- Safe abortion services for all indications guaranteed by law must become an integral part of comprehensive reproductive health care and services in order to minimize the unnecessary death and morbidity caused by unsafe abortion.
- Data on unsafe abortion must be collected nationally in order to record its magnitude and impact on women's health.
- Wide public and professional awareness should be raised about the Fatwa No.4/2005 that allows abortion where the pregnancy is the result of rape (up to 40 days' gestation).

Those potentially responsible: The Ministry of Health, BKKBN, Parliamentarians, professional associations, particularly POGI, IBI, IDAI), Ministry of Internal Affairs.

3.5 Low level of birth registration

3.5.1 Health related considerations

If infants and children are not officially registered, they are likely to suffer in a number of ways. For instance, they may not be able to access health services free of charge, to enter formal education, or to access other social benefits. In essence, children who are not registered at birth do not officially exist, and are thus handicapped in many different ways through life.

In Indonesia only 54 percent of children are registered at birth. Children born in urban areas, and/or to mothers with completed secondary education, are more likely to be registered than those in rural areas, and those whose mothers have little or no education. The most common reason given for not registering a birth is the cost, but other reasons include not knowing that the child has to be registered, not knowing where to register, and the registration office being too far away.

3.5.2 Human rights considerations

The International Convention on the Rights of the Child states that every child has the right to a name and a nationality and a right to protection from being deprived of his or her identity. Article 7 of the Convention states that "the child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality….".

The legal framework in Indonesia clearly call for compulsory, free child registration. The Law on Child Protection explicitly states that every child must be given an identity that shall be stated in a birth certificate and it further regulates the requirements for birth registration.[46] This Law (Article 28(3)) states that birth registrations must be free of charge (Article 28(3)). The National Plan of Action on Human Rights and the Population Law also states that every person is required to register every birth, in accordance with the provision of prevailing laws and regulations.[47] Furthermore, Law No. 32 on Regional Government states that provincial governments have an obligation to manage demographic and civil registration services.[48]

In its latest Concluding Observations, the Committee on the Rights of the Child welcomed the provisions contained in Law No. 23 of 2002 on Child Protection, stipulating that a birth certificate shall be issued by the Government, free of charge. However, it remained concerned by the low rate of birth registration and by the fact that few concrete measures have been taken to increase it. While noting that the Human Rights Act of 1999 guarantees the right of the child to a nationality, the Committee expressed its concern that in some instances, children born out of wedlock may be denied the right to know their father, and children with a foreign father may be denied Indonesian citizenship. The Committee recommended that the State party amend all national and local laws relating to birth registration and that it implement a comprehensive strategy to achieve 100 per cent birth registration by 2015, including by cooperating with UNICEF and other international agencies.[49]

3.5.3 Government effort

Strategies and plans have been elaborated to include dissemination of the importance of having a birth certificate for all citizens, and encouraging health officers and hospitals (district public hospitals, private hospitals, maternity clinics and midwives) to collaborate in providing the Letter of Birth Identification. The Ministry of Internal Affairs also issued a policy on Implementation of Follow-Up Job Training for Civil Registration which consists of civil registration operational procedures (No 893.3/1558/POUD).

[46]Law No. 23 of 2002 on Child Protection, Article 27,28. According to this law the issuing of a birth certificate shall be based upon a declaration by a person who witnessed or assisted at the birth and the production and the issuance of the certificate shall be the responsibility of the government and be carried out in practice at a level that is no lower than that of a village or sub-district. It must be carried out not later than 30 days after filling of an application and it must **be free of charge.**

[47]Population Law article 8 (3) (1992).

[48]Law No. 32 on Regional Government (Article 13).

[49]CRC/C/15/Add.223/2004.

In some districts local government, in recognizing the problem of not having birth certificates, ran "mass birth certificate" programmes through schools, providing birth certificates free of charge to children who did not have the certificate, without requiring parents' marriage certificates. However, it was not a nation wide programme.[50]

UNICEF also supported several activities in the country in collaboration with the government and other actors that included implementation of a birth registration programme in 16 districts/municipalities covering 5 provinces in Indonesia. The programme consists of establishing a memorandum of understanding between related sectors involved in the birth and registration services at district level, legal reform to obtain local government regulations on free birth registration, simplification of the procedures at the Civil Registration Office with the aim of bringing the service nearer to the village level, capacity building of the civil registrars and other stakeholders including community based organizations, and campaigns to increase public awareness to report births.

3.5.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Lack of application of free birth registration law to local regulations

Although the Child Protection Law and the National Plan of Action on Human Rights both call for birth registration of every child free of charge, local regulations (perda) that were issued mainly before the enactment of the Child Protection Law still require fees for birth registration. This is a problem especially for those who are poor and so cannot afford such services. Several local authorities have issued local perda that regulates the fee for issuing a certificate. Some provinces have revised the perda to overrule the fee requirement (e.g. Jogjakarta which issued a new perda (No.3, 2004) stipulating that no registration fee is required, the same practice was followed in Kebumen Perda No. 50/2004).

Discrepancy between the Child Protection law and the Law on Marriage with regard to birth registration

Local government regulations on civil registration of a child require a marriage certificate for the registration, and issue different birth certificates for children born in wedlock and out of wedlock ("anak luar nikah"). This legal requirement might result in the lack of registration of children whose parent/mother tries to avoid stigmatizing the child and/or themselves. Such provisions are contradictory to the Constitution, the Child Protection Law and the Provisions of the Law on Human Rights, all of which call for non-discrimination.

Barriers in policies, strategies, plans and implementation

The Birth Registration Programme is implemented only in some parts of the country, in 16 out of 430 districts/municipalities covering 5 out of 33 provinces in Indonesia.

In 2004, Presidential Decree No 40 was issued on the National Plan of Action of Human Rights 2004–2009. Among the actions mentioned is the application of norms and standards of human rights instruments "to enhance the rights of the child to obtain a birth certificate". The same action was stated in the previous Plan of Action of Human Rights. However, despite this initiative, there is still no comprehensive national effort to address the needs of low-income children living in remote,

[50]Sampanag birth registration programme.

isolated and/or rural areas and whose mothers have low educational and socio-economic status. In addition, clarity is needed on which government sector is responsible for the implementation of the law and the national plan of action.

3.5.5 Recommendations for priority actions

Legal and regulatory measures

- Local government regulations on civil registration should be revised according to international human rights principles and should not be discriminatory or stigmatize the child who is born out of wedlock *("anak luar nikah").*
- All local regulations must ensure that birth registration is issued free of charge, and be implemented and enforced in order to make registration accessible for all, including the poor.

Those potentially responsible: The Ministry of Law and Human Rights; the Ministry of Internal Affairs, Ministry of Women's Empowerment

Policies, strategy, health system measures

- In order to assure that every newborn child receives a birth certificate, local governments and health providers should coordinate by clarifying roles and responsibilities. Coordination should be from the village level up to the district, with a clear designation of who will sign the certificate and who will be responsible for keeping the documentation.
- Those who are responsible for the initial registration right after the birth of the child (mother, doctor, midwife, traditional birth attendant *(dukun)* should be informed, educated and empowered to be able to do so.
- The Birth Registration Programme should be implemented all over the country, with special attention to low-income children living in remote, isolated and/or rural areas and whose mothers have low educational and socio-economic status.

Those potentially responsible: the Ministry on Law and Human Rights, the Ministry of Health, the Ministry of Internal Affairs, BKKBN, local governments.

3.6 Violence against women

3.6.1 Health-related considerations

Data from around the world suggest that there is an extensive negative impact of violence on women's sexual and reproductive health: an increased risk of STIs including HIV, unwanted pregnancies, complications of pregnancy, having a low-birth weight baby, and long-term mental health problems which have repercussions on all aspects of their own and their children's health. Violence may also be linked to a sizable portion of maternal death.[51] Violence against women is often perpetrated by men who are known to the woman, such as their intimate partners and/or close family members. It has also been found that women who are pregnant may be at increased risk of violence from an intimate partner.[52] Women who are sexually abused in childhood are also at greater risk of being physically or sexually abused as adults. Studies have found that victims of sexual abuse tend to start having voluntary sex significantly earlier than non-victims, and that sexual abuse is linked to other risky behaviours including having

[51]Taking action: achieving gender equality and empowering women. Achieving the Millennium Development Goals. Millennium Project. Task Force on Education and Gender Equality. 2005. Page 15.
[52]García-Moreno C, Hansen HAFM, Ellsberg M, Heise L, and Watts C. WHO Multi-country study on women's health and domestic violence against women. Geneva, World Health Organization, 2006.

sex with many partners, using drugs and alcohol, not using contraception and trading sex for money or drugs.[53 54 55]

In Indonesia there is no systematic collection of data on violence against women at the national level. Reports from women's crisis centres, police stations and health facilities and some other institutions (court, physiological services, etc.) indicate that violence against women is increasing. Data indicate that 72 percent of women reporting violence are married and that the perpetrator is nearly always their husband.[56] This is confirmed by additional data showing that for the majority (80 percent) of women reporting to crisis centres, the perpetrators are husbands, former husbands, boyfriends, relatives or parents. Of the women reporting, 4.5 percent were under 18 years old.[57] Data from a crisis centre also show that 9 out of 10 women who make use of its services experienced more than one type of violence (physical physiological, sexual, economic/financial violence and abandonment). In nearly 17 percent of the cases, the reproductive health of the women was affected.[58]

3.6.2 Human rights considerations

It has been affirmed that violence against women constitutes a violation of the rights and fundamental freedoms of women that are enshrined in the Universal Declaration of Human Rights and in various human rights treaties.[59] Furthermore, consensus documents call for the elimination of all forms of discrimination against women and children and demand an end to all forms of violence against women and children, including domestic violence. It has been also recognized by the international community that violence against women has a serious health and development impact and is a gross violation of human rights. Depending on the form, violence against women can constitute a violation of the right to non-discrimination, the right to be free from inhuman and degrading treatment, the right to health and, in severe cases, a violation of the right to life. It has been recognized that the Millennium Development Goals cannot be achieved without combating violence against girls and women.[61]

In its latest Concluding Observation to Indonesia, the CEDAW Committee expressed serious concern about the lack of systematic collection of sex disaggregated data and the lack of documentation on the extent, forms and prevalence of violence against women in Indonesia. The Committee urged the government to collect, as a matter of priority, data on the extent, causes and consequences of the problem of violence against women in Indonesia. The Committee also emphasized

[53]Kyriacou DN et al. Risk factors for injury to women from domestic violence against women. *New England Journal of Medicine,* 1999, 341:1892-1898.

[54]Thompson M, Saltzman LE, Johnson H. Risk factors for physical injury among women assaulted by current or former spouses. *Violence against women,* 2001, 7:886-899.

[55]Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine,* 2002, 55:1603-1607.

[56]National Commission on Violence Against Women. *Annual Report on Violence Against Women, 2004 and 2005.*

[57]Mitra Perempuam, Statistic on Domestic Violence, Fact sheet, 2005.

[58]Mitra Perempuam, Annual report on Violence Against Women and Women's Crisis Centers, 2005.

[59]Declaration on the Elimination of Violence against Women. General Assembly Resolution (A/RES/48/104) 1994.; Elimination of domestic violence against women. General Assembly Resolution (A/RES/58/147) 2004Universal Declaration of Human Rights, article 3.5; International Covenant on Civil and Political Rights, article 7, 9.; Universal Declaration of Human Rights, article 23; International Covenant on Economic, Social and Cultural Rights, articles 6 and 7.; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Convention on Elimination of all forms of Discrimination against Women.

[60]ICPD Programme for Action, Beijing Platform for Action.

[61]Taking action: achieving gender equality and empowering women. Achieving the Millennium Development Goals. Millennium Project. Task Force on Education and Gender Equality. 2005. Page 15.

the need for gender sensitization of authorities, including judiciary, law enforcement officers, lawyers, social workers, health professionals or others who are directly involved in combating violence against women.[62]

Furthermore, the Committee on the Rights of the Child in its latest concluding observations to Indonesia expressed its concern at the high number of child victims of violence, neglect and abuse-including sexual abuse in the country. It called on the Government of Indonesia to expand current efforts to address the problem of child abuse, including sexual abuse, and ensure that all victims of violence have access to counselling and assistance and ensure that the perpetrators of violence against children are duly prosecuted.[63]

With regard to the national protection of violence against women, there are two specific national laws that deal with such violence: the Criminal Code of Indonesia and the Law on Domestic Violence. The Criminal Code(1946) has several provisions that criminalize violence against women, depending on the nature and severity of the criminal act but only if the victim is not the spouse of the perpetrator. In 2004 the Law on Domestic Violence was enacted. It states that "the Government is responsible for making every effort to prevent domestic violence". The Law imposes sanctions depending on the severity and type of domestic violence act.[64]

3.6.3 Government effort

The Government of Indonesia has undertaken a number of measures to implement the laws, and to address the problem of violence against women. In 1998, a Presidential Decree (No. 181) was issued, leading to the establishment of the National Commission of Violence Against Women. This Commission has been acting on various levels, including collecting data on different aspects of violence against women, conducting public awareness campaigns, publishing reports, and supporting women's crisis centres. In 2001 a National Action Plan on Elimination of Violence against Women was elaborated by the Ministry of Women's Empowerment that was a result of a multi-stakeholder collaboration started in 1999. The aim of this plan was to implement the concept of "zero tolerance" for violence against women. It is being implemented in seven sectors including law and justice, military, education, religion and culture, health care, employment and the media. The plan also called for the adoption of a law on the elimination of domestic violence and as a result the Law on Elimination of Domestic Violence was enacted in 2004. In terms of enforcement, the Law on Elimination on Domestic violence has been applied in 9 cases through 34 courts in the year 2005.[65]

Furthermore, for the implementation of this Law, the Government issued a Regulation (No.4, 2006) regarding the implementation and cooperation on the recovery of victims of domestic violence.

Using the momentum of the elaboration of the plan, the existing women's crisis centres (NGOs) in Jakarta, Yogjakarta and other provinces extended the services to hospitals, police stations (women's desk), forensic facilities and women shelters with the support of the Commission on Women and the Ministry of Women's Empowerment. In 2002, the Ministry of Health developed a guideline for the prevention and management of violence against women for primary health care services. This programme is intended to build and develop

[62]CEDAW A/53/38/Rev.1 (1998).

[63]CRC/C/15/Add.223./2004.

[64]Law no. 23 of 2004 on Domestic Violence.

[65]Record of the National Commission on Women.

collaborative training on law enforcement for all those potentially involved directly in handling cases on Violence against Women. In 2003, the Ministry also developed guidelines on Integrated Services for Victims of Violence against Women and Violence against Children for use in hospitals.

The Ministry of Women's Empowerment elaborated a Strategic Plan for the period 2005-2009 to further eliminate all forms of violence against women. Among the priorities to be implemented are: to intensify the campaign on violence against women and children, and to elaborate more comprehensive penal law instruments to protect every individual from all forms of violence, exploitation and discrimination, including domestic violence. At the provincial level women's empowerment bureaus were established in local governors' office's nationwide. In some provinces such as Yogjakarta several activities have been undertaken to implement the national action plan. For instance, a memorandum of understanding was elaborated by the hospital, crisis centre and the police to coordinate and provide integrated services for the victims of violence. Training has been conducted by NGO crisis centres for police officers and health providers. Public education campaigns have been carried out. However, in other provinces, where the women empowerment bureau is weak or non-existent and/or there are no strong women's NGOs, these activities have not yet been implemented.

3.6.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Discrepancy between the Law on Domestic Violence and the Criminal Code with regard sexual violence in marriage

The Government of Indonesia made significant efforts to provide legal protection for women by adopting a law on Domestic Violence.[66] However, while the Domestic Violence Law encompasses all forms of violence against women irrespective of marital status, Articles 285 and 286 of the Criminal Code still do not recognise sexual violence within marriage.

Lack of legal protection for the victims of sexual violence

The right to liberty and security of the person and the right to be free from inhuman and degrading treatment are enshrined in Law No 12/ 200 on the ratification of the Covenant on Civil and Political Rights, and Law No 5/1998 on the ratification of the Convention Against Torture. These rights have been increasingly applied internationally to cases of denied abortion when the pregnancy is a result of rape or incest. Furthermore, Law No 7/1984 on the ratification of CEDAW and Law No11/2005 on ratification of the Covenant on Economic, Social and Cultural Rights both call for the elimination of all forms of discrimination against women, as well as the provision of the highest attainable standard of physical and mental health that is also enshrined in the Law 39/1999 on Human Rights, Law No. 23/1992 on Health, and Law No. 23/2003 on Child Protection.

In Indonesia, while both the Criminal Code and the Domestic Violence Law recognize rape as a serious crime, the Health Law and regulations do not allow women to deal with the possible consequences of rape - such as unwanted pregnancy and services free of charge for the victims of violence. The lack of legal regulation on provision of safe abortion services for women who are victims of rape or incest, can result in serious harm to the physical and mental health of the victim. For that reasons,

[66]Law no. 23 of 2004 on Domestic Violence.

the Health Law, which does not allow access to safe abortion services when the pregnancy is a result of rape and incest, appears to constitute a violation of international human rights standards as enshrined in international human rights treaties ratified by Indonesia, the Constitution and various national laws.

Although it may be a common belief that abortion is not allowed because of religious reasons, religious authorities have recently recognized this discrepancy, and issued a Fatwa in October 2005 stating that, according to Islamic Law, abortion is allowed in cases where pregnancy is a result of rape up to 40 days' gestation. However, this Fatwa does not constitute a national law but a religious regulation.[67]

Barriers in policies, strategies, plans and implementation

Although some data are available, without comprehensive national and provincial level data on the prevalence of violence against women, it is very difficult to precisely assess the magnitude of the problem and thus to plan exactly how best to tackle the problem. In order to do so, a population-based survey would allow a more scientifically-based estimate of the prevalence. The reporting system would also need to be expanded and improved. For example, knowing whether the prevalence varies from one province to another would allow the Government to focus training of law enforcement officers and health workers in areas where there is most need.

3.6.5 Recommendations for priority actions

Legal and regulatory measures

- The Criminal Code and the Law on Domestic Violence should be harmonized and immediate action should be taken to ensure that the revised Criminal Code takes into account the existing Law on Domestic Violence with regard to marital rape.
- The ongoing process of amendment of the Health Law no 23/92 should be accelerated to ensure the provision of safe abortion services in cases of rape and incest.
- A decree should be issued regarding services free of charge for victims and survivors of violence against women, including "visum at repertum", treatment of physical injuries as well as psychiatric and psychological assistance.

Those potentially responsible: The Ministry of Law and Human Rights; the Ministry of Health; the Ministry of Women's Empowerment; the Ministry of Social Affairs; Chief of Police Department; Judiciary system.

Policies, strategies, health system measures

- National and provincial data on violence against women should be systematically collected through different means.
- The domestic violence law and its implementation should be socialized to all, with special attention to law enforcers.
- Measures should be put in place to ensure that violence against women cases are properly recorded and monitored in all health facilities.
- All health personnel should receive in-service training on violence against women and be able to record violence against women cases. Pre service training curricula should also incorporate the topic.
- Measures should be taken to ensure that the cause of death of every woman suspected to be a victim of violence is appropriately documented.

[67]Fatwa Majelis Ulama Indonesia Nomor 4 tahum 2005 (Ulamas -MUI- Fatwa No. 4/2005).

- Socialization of the existing policy on Zero Tolerance on violence against women should be reinforced at all levels of the bureaucracy.

Those potentially responsible: the Ministry of Health; the Ministry of Women Empowerment; the Ministry of Social Affairs; Chief of Police Department.

3.7 Female genital mutilation/ circumcision (FGM/C)

3.7.1 Health related considerations

A WHO multi-country study on the obstetric sequelae of FGM/C shows that FGM/C is dangerous for women and can be deadly for newborns. These negative health consequences increase with the severity of the type of FGM/C carried out, but no form of the practice has any health benefit for girls, women and babies.[68]

A number of recent studies show that FGM/C is prevalent in Indonesia. It is mainly done on girls between 0-9 years old, and especially in areas where cultural influence of traditions is stronger. In a recent study, two main types of FGM/C were found to be practised: "symbolic only" types where there is no incision or excision (28 percent of cases); and "harmful" forms involving incision (49 percent) and excision (22 percent).[69] Sixty-eight percent of reported cases were conducted by traditional providers, and the remaining 32 percent were performed by midwives or other health care providers. Evidence shows that extensive medicalization of FGM/C has started in some parts of the country and is already established in others. Many maternity clinic midwives have begun to market FGM/C as part of a birth delivery package. The study personnel found that trained providers were more likely to perform more invasive forms of FGM/C, indicating that so-called "medicalization" of the practice is a source of danger.

3.7.2 Human rights considerations

International human rights treaties, such as CEDAW (article 2) and the Convention on the Rights of the Child, oblige governments to end harmful practices against women. Furthermore, international consensus documents, particularly the Cairo Programme of Action[70] and the Beijing Platform for Action,[71] commit governments to eradicating these practices that include FGM, early marriage, early pregnancy and violence against women. Declarations and resolutions adopted by inter-governmental organizations, such as the Declaration on the Elimination of Violence Against Women adopted by the United Nations General Assembly (1993), call for the elimination of the practice and characterize FGM as a form of violence. FGM has been recognized as a violation of international human rights such as the right to life, the right to physical integrity as well as a violation of the right to health enshrined in various international human rights treaties and national laws, and it has also been recognized as a violation of the rights of the girl child enshrined particularly in the Convention on the Rights of the Child.

With regard to national legal protection, Law No. 7 adopted in 1984 on the ratification of CEDAW clearly condemns all forms of discrimination against women and specifically condemns the practice of FGM. The Law on Child Protection specifically requires that "every child shall be

[68]Female Genital Mutilation. and Obstetric Outcome: WHO collaborative prospective study in six African countries The Lancet 2006; 367:1835-41.

[69](Budiharsana M et al. *Female circumcision in Indonesia: extent, implications and possible interventions to uphold women's health rights.* Jakarta, Population Council. 2004).

[70]ICPD+5 paragraph 44.

[71]FWCW paragraph 224.

entitled to receive protection from discrimination, harsh treatment, violence, abuse and other forms of mistreatment.[72]

3.7.3 Government effort

The Government has recently made significant efforts towards eliminating the harmful practice of Female Genital Mutilation/Circumcision.

Various NGOs and professional associations such as the Indonesian Midwives Association (IBI), the Indonesian Medical Association (IDI) and the Indonesian Paediatrics Association (IDAI) initiated a workshop where all studies regarding FGM/FC were presented. Based on the conclusion of the workshop it was decided to develop advocacy materials in order to eliminate FGM/C.

As a result of various workshops, the Ministry of Health issued a circular letter signed by Director General of Community Health (dated April, 2006), which was based on an agreement that female circumcision has no particular benefit for the health of women. In addition, it could endanger the health of the girl child and therefore it was agreed that female circumcision should not be carried out by medical personnel. It was also agreed that all chairpersons of all professional organizations should disseminate this information to their members to ensure that all practices related to FGM/C be stopped.[73]

The standards for midwifery service adopted by the Ministry of Health from the WHO standards on Midwifery Practice for Safe Motherhood[74] clearly state that midwives should avoid harmful tradition practices and support good practices.

3.7.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Lack of regulation on the elimination and against medicalization of the practice

The Convention on the Rights of the Child, CEDAW, the Constitution of Indonesia, and the Child Protection Act require that "every child shall be entitled to receive protection from discrimination." However, there are no regulations currently in Indonesia that address FGM as a harmful practice specifically, although, as mentioned above, the Ministry of Health in Indonesia recently developed a circular letter, signed by the Director General of Community Health on the prevention and management of violence against women related to female circumcision (20th April 2006),

Several countries where FGM is prevalent have applied legislative and regulatory measures to condemn the practice. These include the elaboration of punitive measures against persons who perform or assist in FGM, amendment of child protection laws, and elaboration of regulations on demedicalization of the practice.

Furthermore, research on Islamic Law shows that there is no clear indication for the practice and especially not for those forms that cause harm.[75]

[72]Republic of Indonesia Law number 23/2002 on Child Protection, article 13.

[73](Circular for Health Personnel on Prevention and Prohibition on Medicalization of Female Circumcision, Ministry of Health, Director General of Community Health, 20 April, 2006).

[74](Standards for Midwifery practice for Safe Motherhood, World Health Organization, Regional Office for South–East Asia, New Delhi, 1999, Regional Publication, SEARO, NO. 38, states (Standard Pelayanan Kebidanan, Deapartemen Kesehatan Republik Indonesia, 2001. Buku 1. Page).

[75]Budiharsana M et al. Female circumcision in Indonesia: extent, implications and possible interventions to uphold women's health rights. Jakarta, Population Council. 2004).

Barriers in policies, strategies, plans and implementation

Although a multi-stakeholder process has started to address the increasing medicalization of the practice of female circumcision, high level commitment is needed to justify the elaboration of directives and standards within the health system in order to prohibit the practice of female circumcision by health personnel.

3.7.5 Recommendations for priority actions

Legal and regulatory measures

- A decree should be issued, based on the circular letter on demedicalization of female circumcision by health personnel.

Those potentially responsible: The Ministry of Health; the Ministry of Women's Empowerment

Policies, strategy, health system measures

- Medical professional associations should be encouraged to issue policies on the elimination of FGM/C.
- Action should be taken to eliminate FGM/C from the service package for newborns offered by hospitals, clinics and other health services.
- Information about the proper interpretation of all religions concerning female circumcision, and regarding the harmful health consequences of the practice of FGM/C should be widely disseminated and socialized.

Those potentially responsible: The Ministry of Health; the Ministry of Women's Empowerment; the Ministry of Religious Affairs; religious leaders of all faiths; health professional associations (Indonesian Midwives Association, Indonesian Obstetrics and Gynecology Association, Indonesian Medical Association, Indonesian Pediatricians Association and the Indonesian Nurses Association).

3.8 Lack of knowledge about, and increasing prevalence of STIs and HIV/AIDS

3.8.1 Health related considerations

Some of the major sexually-transmitted infections, such as chlamydia, gonorrhoea, trichomoniasis, genital ulcer disease and herpes, are responsible for major problems for the woman during pregnancy, as well as for the health of the newborn. They also increase the risk of the HIV transmission.

The analysis from the data compiled here revealed that, in Indonesia the prevalence of STIs is not documented at the national level. Data from surveillance among vulnerable groups such as sex workers show that cases of syphilis and gonorrhoea are high. It has been documented that the prevalence of HIV is still low among the population in general, but rapidly increasing, especially in certain provinces.

Knowledge about STIs other than HIV/AIDS among Indonesian young adults is limited. Two out of three women and six out of ten men have no knowledge of symptoms of STIs. Among those who say that they have heard of STIs other than HIV/AIDS, a significant proportion cannot name any symptoms. Overall, 18 percent of women reported no knowledge of the symptoms of STIs in women and 17 percent have no knowledge of the symptoms of STIs in men. Men, on the other hand, are less knowledgeable about STI symptoms in women than in men. For example, while 16 percent of men mentioned two or more symptoms of STIs in a man, only 5 percent mentioned two or

more symptoms in a woman.[76] The same survey indicates that less than 40 percent of respondents can name one way to avoid HIV/AIDS and only 10 percent of respondents name correctly two ways to avoid HIV/AIDS.

Data also show that people in urban areas and with higher education have more access to information than those living in rural areas and with lower education. Various surveys at provincial level done by various NGOs also confirmed the above figure on the extremely low level of knowledge about HIV (and reproductive health overall) among adolescents.

3.8.2 Human rights considerations

It has been recognized that in many parts of the world women and adolescent girls lack adequate access to information and services necessary to ensure their sexual health and prevent, detect and treat sexually transmitted infections, including HIV/AIDS. Governments agreed that the protection of human rights remains critical to a successful response to sexually transmitted infections, including HIV/AIDS. Furthermore, governments agreed to strengthen or enforce appropriate legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups.

They further agreed that since globally women and girls are disproportionately affected by HIV/AIDS, they should develop and accelerate the implementation of national strategies that increase people's ability to protect themselves from HIV infection. It has been accepted that governments must implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including sexual and reproductive health and through education that promotes prevention, and gender equality within a culturally and gender sensitive framework. It has been agreed that governments will accelerate the implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls.[77]

3.8.3 Government effort

A presidential Decree established the Indonesia National AIDS Commission in 1994. The Commission promotes the National AIDS Strategy, a collaborative effort by government, non-governmental organizations, the private sector, and the community. This strategy promotes a healthy lifestyle, safer sex through use of condoms, safe injections, and supports people living with HIV/AIDS. Similar programmes have been designed and committees have been created at the provincial and district level to respond to the new reality of HIV/AIDS in locally appropriate ways (Ministry of Health 2001, cited in IDHS 2002-2003).

The Ministry of Health also established an Integration Programme which is related to a strategy of HIV/AIDS management for pregnant women. This programme covers:

a. General policy on HIV mother to child transmission in accordance with the overall policy on maternal and child health, and a policy on HIV/AIDS management in Indonesia.
b. Service for prevention of HIV mother to child transmission are planned to be incorporated into maternal and child health care services as well as family planning services at every level of health care services.

[76]Indonesian Young Adult Reproductive Health Survey, 2003.

[77]Resolution adopted by the General Assembly. S-26/2. Declaration of Commitment on HIV/AIDS. Follow up of this declaration is available at: http://www.unaids.org/en/AIDSreview2006/AIDSReview2006/default.asp.

c. Every woman who visits a maternal and child health and family planning service at every level of the health system will receive information on prevention of mother to child HIV transmission, especially during pregnancy, delivery, and breastfeeding.

As part of the implementation of the general policy, guidelines have been produced on prevention of mother-to-child transmission of HIV, which includes providing psychological, social and treatment support to HIV positive mothers and their children.

East Java province moved ahead responding to the need to have a formal law to address HIV/AIDS by enacting local government regulation no 5/2002 on prevention and management of HIV/AIDS.

3.8.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

There is a lack of a legal and regulatory framework on the prevention of HIV/AIDS and on access to health services for positive people. Given the extreme way in which people with HIV are stigmatised and discriminated against, there is need for a strong policy and implementation mechanisms that ensure people are not stigmatised, especially within health services.

Barriers in policies, strategies, plans and implementation

Because of the rapidly increasing prevalence of HIV in Indonesia, implementation of strategies and actions geared to both the prevention of HIV/AIDS (especially through public information campaigns), as well as the diagnosis and treatment, require further measures to be taken.

Information and integrated reproductive health programmes and services related to sexually transmitted infections are apparently very inadequate and in need of further resources and training (both pre-service and in-service) for health personnel.

There is concern that the National AIDS Commission solely not an effective enough mechanism to combat the epidemic.

3.8.5 Recommendations for priority actions

Legal and regulatory measures

- The protection of the rights of HIV positive people must be specifically included into the ongoing process of the amendment of the Health Law.
- Mechanisms should be developed to control and make sure that every HIV positive person has access to health care and services without any discrimination on the basis of their HIV status. A decree should be issued to formalize the decision.
- HIV positive people must not be discriminated against at the workplace. A special decree should be issued to deal with this issue.

Those potentially responsible: The Ministry of Health, the Ministry of Manpower, the Ministry of Law and Human Rights, professional associations, local and district health offices.

Policies, strategy, health system measures

- A policy should be developed to record national data collection on STIs, not only HIV/AIDS.
- Every public health center (Puskesmas) must be able to provide comprehensive and affordable reproductive health services which include screening and treatment for STIs and HIV/AIDS.
- The role and responsibility of the National AIDS Commission must be revised and strengthened in order to be more effective in promotion and education efforts to the community in preventing HIV/AIDS. In this effort, the National AIDS Commission should develop networks

with local NGOs, donor partners and other community groups.

Those potentially responsible: The Ministry of Health, the Ministry of Social Welfare, National AIDS Commission.

3.9 Inadequate provision of privacy, confidentiality and informed consent

3.9.1 Health related considerations

Privacy, confidentiality and informed consent are critical to the functions of reproductive and sexual health clinics, because patients will feel unusually exposed and vulnerable to observations by strangers. If privacy and confidentiality not ensured, patients may not return for care important to their own reproductive health and to the health of others, and potential patients may be deterred from going to them.[78]

There are very few available data about the quality of care on privacy, confidentiality and informed consent in Indonesia. However, anecdotal evidence indicates that the system on patient's medical documentation needs improvement, procedures of informed consent need to comply with national and international standards, and socialization of patients' rights needs to be improved.[79] Furthermore, evidence shows that privacy during consultation is not provided for women such as for insertion of IUD, and implants.[80]

3.9.2 Human rights considerations

Privacy and confidentiality have been recognized as basic human rights. International treaties, consensus documents and the treaty monitoring bodies, such as the CEDAW Committee, call on State parties to require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.[81]

3.9.3 Government Effort

Over the past decades various laws and government regulations have been elaborated to safeguard the privacy of patients, provide confidentiality of medical records and oblige providers to seek informed consent from their patients before a medical intervention. Specifically, Law No. 29 of 2004 on Medical Practice declares (Article 47) that medical records are the property of the doctors, dentists or health care facilities, while the content of the medical records is the property of the patient. It states that the confidentiality of the content of medical records must be kept and guarded by doctors, dentists and the head of health care facilities. This Law also states that for any medical actions, approval of the patient has to be sought after a comprehensive explanation has been given. (Article 45 Paragraph) This Law (Article 52) also enshrines the various rights of patients including the right to receive a comprehensive explanation regarding medical procedures, to request a medical opinion, to refuse procedures and to receive the content of their medical records.

[78]B. M. Dickens and R.J.Cook, 'Law and Ethics in Conflict over Confidentiality?', Int. J. Gynecol.Obstet. 70 (2000), 385-91.

[79]"Two is Enough", written by Sarwono Solita (2005), Leiden University, Nederland.

[80]Damayanti, E. 2005. "Policy on Implants in Province of Jakarta: A Case Study on A Mass Campaign on Implants in East Jakarta". A Published Post Graduate Thesis Women Studies Program. Jakarta: University Indonesia.

[81]CEDAW, General Recommendation 24, UN GAOR, 1999, Doc. No. A/54/38/ Rev.1. para.31.e.

3.9.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in policies, strategies, plans and implementation

Although the Law on Medical Practice safeguards the principles of confidentiality, privacy and informed consent, these provisions do not seem to be implemented in practice.

Although the BKKBN policy states that, every family planning client must be given adequate information [informed choice] from the trained provider and then she/he gives informed consent before receiving the treatment, data need to be collected on whether medical and ethical regulations related to privacy, confidentiality and informed consent are implemented in practice at different health service levels.

3.9.5 Recommendations for priority actions

Legal and regulatory measures

- Client rights should be included in the draft of the new proposed law on health and hospitals.

Policies, strategy, health system measures

- The Law on Medical Practice should be fully implemented to ensure client rights, including on privacy, confidentiality and informed consent.
- A policy which assures that the client's rights are adopted in every health care service (public and private) should be developed and adopted and become part of the curricula and implemented in pre-service training.

Those potentially responsible: The Ministry of Health, the Ministry of Law and Human rights, professional associations.

3.10 Unequal access to education for girls and women

3.10.1 Health related considerations

Evidence shows that higher levels of education play an important role in promoting health. Studies have found that only at secondary or higher levels of schooling does education have a significant beneficial effect on women's own health outcomes. Higher levels of education—six years or more—always have a positive effect on a woman's use of prenatal and delivery services and postnatal care, and the effect is increases with higher levels of education. Education is also strongly related to women's age at marriage. Girls with fewer than seven years of schooling are more likely to be married by age 18 than those with higher levels of schooling. Evidence also consistently shows that women with less than primary schooling tend to marry earlier, bear children earlier, and have more children than women who have completed primary schooling. Multi-country studies confirm that girls who drop out of school and marry in their early teens typically begin childbearing before their bodies are mature and continue with closely spaced births. The result is high mortality among both children and mothers. There is a similar relationship between higher levels of education and the incidence of violence against women. Female education can reduce violence against girls and women and enhance their control over their own bodies (although it does not eliminate violence).[82]

[82]Taking action: achieving gender equality and empowering women. Achieving the Millennium Development Goals. Task Force on Education and Gender Equality. Millennium Project. 2005. Chapter 3.

Although literacy and primary and secondary school enrolment of girls improved in the last decade(s) in Indonesia, and the Government made significant effort to improve girls' enrolment in primary and secondary education and reduce gender differences, data indicate that the literacy rate among females is lower compared to males and the net primary school enrolment rate is lower for females than for males. Males tend to be in school longer than females. Furthermore, the most recent national survey data indicate that around 62 percent of women had only primary education or less. Generally the level of education is lower among the rural population than the urban one, and this difference exists among the provinces as well.

3.10.2 Human rights considerations

International human rights treaties and consensus documents recognize the right of everyone to education. Governments agreed, in the context of human rights, that primary education shall be compulsory and available to all; and secondary and higher education in its different forms, shall be made generally available and accessible to all by every appropriate means. CEDAW declares that states shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education. CEDAW Article 10 also calls for the reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely.

In terms of national human rights and legal protection, the Constitution of Indonesia enshrines the right of every citizen to education (1945 Constitution article 31 paragraph 1, 2). The Law on the National Education System declares that every citizen age 7 to 15 years is obliged to attend basic education (Article 6) that corresponds with the Law on Child Protection that requires the Government to provide a minimum 9 years basic education for all children. The Law on the National Education System also states that the Government and regional governments should secure the implementation of compulsory primary education free of charge. It states that compulsory education is the responsibility of the country which is implemented by government, regional government and community educational institutions (Article 34). The Law on Child Protection specifies that the Government shall be responsible for providing free education or assistance or special services to children from families of limited means and children who live in remote areas. The Constitution also declares that the state shall give priority to the education budget by allocating at least twenty percent of the state's budget as well as of the regional budgets to meet the requirements of implementing national education.

Despite all the effort mentioned above, the Committee on the Rights of the Child in its latest concluding observation to Indonesia was very concerned that education is not free, even at primary level, and that higher education is not affordable for many families. It was also very concerned about the high dropout rates, and the fact that married children and pregnant teenagers do not generally continue their education. The Committee recommended that the State of Indonesia strengthen measures to achieve universal and free primary education; progressively ensure that girls and boys, from urban, rural and least developed areas, have equal access to educational opportunities, without any financial obstacles; and to adopt effective measures to decrease the dropout, repeat and illiteracy rates. It specifically recommended that the State provide education opportunities for married children and pregnant teenagers.[83]

[83] CRC/C/15/Add.223. 2004. Para 60-64.

3.10.3 Government effort

The plan of implementation at the National level is reflected in the Presidential Decree No. 7 of 2005 Mid-Term Development Plan, Chapter 27: Improvement of Community Access towards Qualified Population. Paragraph D.2 declares that the State will provide nine years free education to all Indonesian citizens.

The Ministry of National Education elaborated several policies and short-medium and long term development plans in order to realize equitable and qualified basic and intermediate education for the whole community. Furthermore the Ministry integrated the concept of gender equality into its policies, plans and programmes. It includes the improvement of girls' enrolment in primary and secondary education, introduction of gender-responsive fellowships and reduction of school drop-out rates of female students, improvement of the provision of literacy education services particularly for women. The plans and programmes also include the appointment of focal points for gender mainstreaming throughout the education sector, provision and dissemination of guidelines for the integration of gender equality into educational materials, etc. In its National Action Plan for the Elimination of Violence Against Women, the Ministry of Women's Empowerment emphasizes the importance of elimination of gender discrimination in the education system.

3.10.4 Discrepancies in laws, regulations, policies, strategies and implementation

Barriers in laws and regulations

Although national laws clearly declare compulsory education for all citizens and the Government aims to provide access to secondary and higher education without discrimination on the basis of sex and other grounds, local school policies and practices are still expelling pregnant girls from school. These rules are contradictory to the principles of the Constitution, the Laws on Education, on Child Protection, the Law on CEDAW the Law on Human Rights and the principles of other international human rights treaties and agreements.

Barriers in policies, strategies, plans and implementation

Even though the Laws explicitly state that Basic Nine Years Education is free for every citizen, the actual situation is different. Payment is still collected to support the basic education system.

3.10.5 Recommendations for priority actions

Legal and regulatory measures

- Local schools should be forbidden by law to expel pregnant girls and young women from school.

Those potentially responsible: The Ministry of Education, the Ministry of Health, the Ministry of Social Welfare, local governments.

Policies, strategy, health system measures

- Perdas to ensure budget allocation for the education of girls and young women should be issued.
- Policies on enhancing higher level education of women/vocational training should be adopted.

Those potentially responsible: The Ministry of Education; the Ministry of National Planning. Board

Non-discrimination, equality and especially vulnerable groups

4

Non-discrimination is one of the main principles of a rights based approach or application of human rights to development, including health. The application of a human rights approach includes that particular attention is given to discrimination, equality, equity and vulnerable groups. These groups include women, minorities, indigenous peoples and others, depending on the specific country situation.[84]

4.1 The right to non-discrimination and equality

Non-discrimination is among the most fundamental principles of international human rights law. When governments, including the Indonesian Government, ratify the Covenant on Civil and Political Rights, the Covenant on Economic, Social and Cultural Rights, CEDAW, the Convention on the Rights of the Child and other human rights treaties, they become legally obliged to prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[85]

While the Constitution of Indonesia does not provide a definition of non-discrimination, the Law on Human Rights declares that "Discrimination means all limitations, affronts or ostracism, both direct and indirect, on grounds of differences in religion, ethnicity, race, group, faction, social status, economic status, sex, language, or political belief, that result in degradation, aberration, or eradication of recognition, execution, or application of human rights and basic freedoms in political, economic, legal, social, cultural, or any other aspects of life".[86] Bound to the principles of these international human rights treaties and national laws, the State is obliged to act against discrimination in all fields of civil and political rights and also of economic, social and cultural rights, including health. In line with international human rights treaties, Law No. 23 of 1992 on Health in article 4 states that " Every person shall have the equal right to obtain optimal health".

The duty of States to ensure the right to health and other human rights related to safe motherhood, on a basis of equality and non-discrimination, implies an obligation to respect, protect and fulfil women's rights to health care, information and education, as well as an obligation to eliminate laws, policies and practices that discriminate on specified and unspecified ("other status") grounds.

It is therefore necessary to examine the ways in which states ensure that they eliminate discrimination on all grounds. While each of these forms of discrimination can be addressed separately, in practice they often overlap. For instance, sex discrimination is frequently aggravated by discrimination on grounds of marital status, race, age, rural residence and class, often leaving women of young age, of minority racial groups and of lower socioeconomic status living in rural areas the most vulnerable to the risk of maternal death. Thus, a state's government is required to address the intersections of different forms of discrimination.[87]

[84]Human Rights in Development, OHCHR. Available at: http://www.unhchr.ch/development/approaches-04.html.

[85]ICPPR articles 2 and 26;

[86]Law No.39 of 1999 on Human Rights in article 1 point c.

[87]General Comment No. 28: Equality of rights between men and women , (article 3) : . 29/03/2000. CCPR/C/21/Rev.1/Add.10. Para 30.

4.2 Non discrimination in the context of maternal health and especially vulnerable groups in Indonesia

Applying human rights requires us to ask: who is vulnerable and why? In order to identify such groups and answer this question, the field test of this Human Rights Tool asked for disaggregated data as far as possible, by sex, age, socio-economic, educational status, geographic residence and other status. The review of the health-related data revealed in Indonesia some recurring patterns with regard to vulnerable groups as described above under the specific health issues. The section below describes the vulnerable groups according to different grounds upon which they might be discriminated against. Each sub-section also describes how these grounds of discrimination relate to maternal and neonatal health.

4.2.1 Sex and gender

All Treaties ratified by Indonesia call for non-discrimination on the ground of sex. Law No. 7 of 1984 on ratification of CEDAW article 1 defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[88]

Governments that ratified CEDAW, including the Indonesian government, need to ensure compliance with the right to nondiscrimination and assess the different ways in which women's right to non-discrimination might be violated in the health care context. For instance, States have an obligation to provide services that only women need thus ensuring women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. When possible, according to the CEDAW Committee, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion.[89]

Vulnerable group in Indonesia: women

As the data show women vulnerable in many different ways. Only women get pregnant, and can die in childbirth or from unsafe abortion. They are also vulnerable to violence and potentially are more vulnerable to HIV infection.

4.2.2 Age

The right to non-discrimination based on age is commonly violated in connection with sexual and reproductive health. Young people are often refused information and services related to their sexuality and reproduction. This fact takes on a heightened significance in light of the increased risk that premature pregnancy brings. It has been established that women who give birth before age 18 are three times more likely to die in childbirth than women over 18.[90]

The Convention on the Rights of the Child that was ratified with Presidential Decree No. 36 in 1990 in Indonesia, as well as Law 23 of 2002 on Child Protection, define a child as a human being below the age of 18 years. The Convention and the

[88]CEDAW article 1.

[89]CEDAW, General Recommendation No. 24 (20th session, 1999)(article 12 : Women and health).

[90]World Bank. World Development Report 1993 – Investing in Health. New York, Oxford University Press, 1993 at 84-117.

Law on Child Protection further declare that "the state shall respect and ensure the rights set in the Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status". This non-discrimination clause is accordingly applicable, among others, to Article 24(1) of the Convention that declares that "States parties shall strive to ensure that no child is deprived of his or her right of access to … health care services."

Furthermore, Law No. 7 of 1984 on ratification of CEDAW states that the state shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. The Convention on Economic Social and Cultural Rights, that was ratified with Law No. 11 in 2005 in Indonesia, call for the provision of the right to health without discrimination, and the prohibited grounds includes age specifically.

Laws and clinical policies and practices that set chronological age limits for types of care, and deny sexual and reproductive health information and services to adolescents that they are capable to request according to their evolving capacities, are contradictory to international human rights treaties ratified by the State and national laws that protects the right to health without discrimination.

Vulnerable group in Indonesia: Girls and young women

Young girls and young women are particularly vulnerable in nearly all the dimensions of reproductive health in Indonesia. Firstly, child/early marriage is still practiced in parts of the country (particularly the rural areas), exposing young girls and adolescents to early sexual relations and pregnancy, which often leads to health problems including maternal morbidity and mortality. On the other hand, unmarried women, particularly young women, do not have access to family planning services because of the restrictive provisions of the population law, thus exposing them to the risk of unwanted pregnancy. Young girls are also vulnerable because they may be subjected to female genital mutilation (female circumcision). Furthermore, despite improvement in educational enrolment of girls and boys, there are still twice as many girls as boys who are not enrolled in primary school.

4.2.3 Socio-economic and educational status and geographical residence

Article 14 of Law No. 7 of 1984 on ratification of CEDAW states that the State shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families. The CEDAW Committee further clarified in its General Recommendation 24 on Women and Health that the full realization of women's right to health can be achieved only if States take steps to facilitate physical and economic access to productive resources especially for rural women, and recognize its interconnection with women's health. It means that States shall ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning.

Furthermore, the Committee called on States to ensure equal access to education, thus enabling women to access health care more readily and

reducing female students' drop-out rates, which are often due to premature pregnancy, as well as ensure women and girls specific educational information to help ensure the well-being of families, including information and advice on family planning. Non-discrimination on the grounds of socio-economic status, geographical residence and educational status has been recognized if other treaties, such as the Covenant on Economic Social and Cultural Rights ratified by Indonesia in 2005.

Vulnerable group in Indonesia: Poor women, women with no or lower education, rural women

Poor women appear consistently as the vulnerable group when considering access to health services, including antenatal, delivery and post-natal services, services for abortion and post-abortion care, as well as services for the diagnosis and treatment of STIs. Women with little or no education and those living in rural areas are also frequently shown to be those who have limited or no access to services, and who suffer greater health consequences of reproductive ill-health. Frequently these three characteristics come together. Likewise, infants whose mothers are poor and/or live in rural areas and/or have little or no education are at higher risk of dying during the first month of life.

4.2.4 Marital status

Law No. 7 of 1984 on ratification of CEDAW requires that women exercise their rights "irrespective of their marital status" and other treaties ratified by Indonesia also prohibit discrimination on the ground of other status that includes marital status. The Human Rights Committee, that monitors compliance with the Covenant on Civil and Political Rights explained in connection with the provisions of the treaty that the right of everyone to be recognized everywhere as a person before the law is particularly pertinent for women, who often see it curtailed by reason of sex or marital status. For instance, the stigmatization experienced by women who are pregnant outside marriage, even when they become so through sexual assaults or abuse, may impair their access to care and the quality of the care they receive, aggravating their vulnerability to unsafe motherhood. The Committee called States to take measures to eradicate laws or practices that allow such treatment.[91]

Vulnerable group in Indonesia: Married and unmarried women

Marital status may be a protective factor in some cases because it provides an enabling condition for women to access reproductive health services. For instance, in Indonesia, only married women can get access to contraceptive and other related services. In this situation, unmarried women are extremely vulnerable. In other cases, being married at an early age is still quite common in Indonesia, and early marriage is a risk factor for too early pregnancy and childbirth and related maternal morbidity and mortality (see Section 3.3.1). Both married and unmarried women of all ages and socio-economic status are vulnerable to violence and the consequences of unwanted pregnancy and unsafe abortion.

4.3.4 Other status

The phrase "other status" would include other prohibited grounds of discrimination, which can affect women's ability to exercise their rights regarding safe motherhood. It means that states have the responsibility to ensure that legislation, policies and practice comply with the obligations to

[91]General Comment No. 28: Equality of rights between men and women, (article 3): 29/03/2000. CCPR/C/21/Rev.1/Add.10. Para 19.

fulfil, respect and protect human rights with regard to all segments of the population, especially those who are particularly vulnerable.

Vulnerable group in Indonesia: women living with HIV/AIDS and sex workers

Both women and men are vulnerable to sexually transmitted infections including HIV, with those whose profile is of overall vulnerability (poor, young, little or no education, in rural areas) being even more so. Sex workers are particularly vulnerable, but women in so-called “low-risk” groups of users of family planning and antenatal care services are also at risk.

5 Conclusions

As described in the introduction, all of the recommendations listed above were discussed and approved at the multi-stakeholder workshop held in September 2006, in Jakarta. Participants also agreed on the different actors responsible for taking the recommendations forward. On the basis of this report, there will be a series of dissemination activities with the different stakeholders, to discuss, plan and implement follow-up activities.

What emerges very clearly from this report is that there are a number legal, regulatory, policy and health system barriers exist which still need to be addressed in order to accelerate progress towards reduction of maternal and neonatal mortality and morbidity. Examining these barriers in the context of Indonesia's human rights obligations under international and national law has demonstrated that action is required to be taken by not only the Ministry of Health but also of a number of other governmental and non-governmental actors, in collaboration with each other.

The National Team sincerely hopes that this report will contribute to, and help to galvanise, both the understanding of how maternal and neonatal health are a question of human rights, and the actions to be taken by all those involved in improving maternal and neonatal health.

Jakarta and Geneva, 10 January 2006